



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 <u>participating providers</u> :<br>\$2,250 single (employee only coverage) / \$4,500 family (two party or family coverage) for policy period<br>For <u>non-participating providers</u> :<br>\$2,500 single (employee only coverage) / \$5,000 family (two party or family coverage) for policy period | 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.                                                                                                                                                                                                                                                                              |
| Are there services covered before you meet your deductible? | Yes. Certain <u>prescription drugs</u> and <u>preventive care</u> is 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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                           |
| 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?              | For <u>participating providers</u> :<br>\$5,000 person / \$10,000 family<br>For <u>non-participating providers</u> :<br>\$6,500 person / \$13,000 family                                                                                                                                                   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                    |
| What is not included in the out-of-pocket limit?            | <u>Premiums</u> , balance-billed charges, health care this <u>plan</u> doesn't cover, certain <u>specialty pharmacy drugs</u> , and penalties for failure to obtain <u>preauthorization</u> for services                                                                                                   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Will you pay less if you use a network provider?            | Yes. See <a href="http://www.emihealth.com">www.emihealth.com</a> or call 1-800-662-5851 for a list of <u>network 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 <u>referral</u> to see a <u>specialist</u> ?                                                                                                                                                                            | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |
|  All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies. |     |                                                                          |

| 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 you visit a health care <u>provider's</u> 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 policy period for some services. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed 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<br>20% <u>coinsurance</u> / outpatient visit<br>20% <u>coinsurance</u> / inpatient services | 40% <u>coinsurance</u>                                    | _____none_____                                                                                                                                                                                                                                                |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                                                                                            | 40% <u>coinsurance</u>                                    | Requires <u>preauthorization</u>                                                                                                                                                                                                                              |
|                                                               |                                                  |                                                                                                                                   |                                                           |                                                                                                                                                                                                                                                               |

| 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) |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.emihealth.com">www.emihealth.com</a> . | Generic drugs                                  | \$7 <u>copay</u> / prescription Retail<br>\$7 <u>copay</u> / prescription Mail Order                                                              | Not covered                                               | Up to a 30-day supply (retail prescription) per <u>copay</u> ; up to a 90-day supply (mail order prescription) per <u>copay</u> . 90-day supply available at Costco, Sam's Club, and Walmart and is subject to 3x the retail <u>copay</u> amount.<br><u>Deductible</u> waived for medications on the Exclusive Maintenance Drug list found at <a href="http://emihealth.com/pdf/Exclusive.pdf">http://emihealth.com/pdf/Exclusive.pdf</a> |
|                                                                                                                                                                                                           | Preferred brand drugs                          | \$21 <u>copay</u> / prescription Retail<br>\$42 <u>copay</u> / prescription Mail Order                                                            | Not covered                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                           | Non-preferred brand drugs                      | \$42 <u>copay</u> / prescription Retail<br>\$126 <u>copay</u> / prescription Mail Order                                                           | Not covered                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                           | <u>Specialty drugs</u>                         | Generic - \$100 <u>copay</u> / prescription<br>Preferred - \$100 <u>copay</u> / prescription<br>Non-Preferred - \$100 <u>copay</u> / prescription | Not covered                                               | Covers up to a 90-day supply (mail order prescription) per <u>copay</u> . The cost of certain drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards your <u>out-of-pocket limit</u> . See <a href="http://emihealth.com/pdf/saveon.pdf">http://emihealth.com/pdf/saveon.pdf</a> for details.                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center) | 5% <u>coinsurance</u> for ambulatory surgical center;<br>20% <u>coinsurance</u> for all other facilities                                          | 40% <u>coinsurance</u>                                    | Some procedures require <u>preauthorization</u>                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                           | Physician/surgeon fees                         | 5% <u>coinsurance</u> for ambulatory surgical center physicians; 20% <u>coinsurance</u> for all other physicians                                  | 40% <u>coinsurance</u>                                    | _____none_____                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you need immediate medical attention</b>                                                                                                                                                            | <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_____                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you have a hospital stay</b>                                                                                                                                                                        | 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_____                                                                                                                                                                                                                                                                                                                                                                                                                            |

| 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 you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <u>coinsurance</u><br>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 for <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). Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the <u>provider</u> recommends the extended stay. |
|                                                                           | 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 60 outpatient visits per injury/illness and 40 inpatient days per policy period.                                                                                                                                                                                                                                                                                                                                                       |
|                                                                           | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                                               | 40% <u>coinsurance</u>                                    | Neurodevelopmental therapy coverage is available for those ages birth thru 6 and is limited to 40 outpatient visits per policy period.                                                                                                                                                                                                                                                                                                                     |
|                                                                           | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                                               | 40% <u>coinsurance</u>                                    | Coverage limited to 30 days per policy period. 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—————                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 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 policy period.                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                           |                                           | 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 (Check your policy or plan document for more information and a list of any other excluded services.)

- |                     |                       |                        |
|---------------------|-----------------------|------------------------|
| • Acupuncture       | • Dental care (Adult) | • Private-duty nursing |
| • Bariatric surgery | • Long-term care      | • Routine foot care    |
| • Cosmetic surgery  |                       | • 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 (15 visits per year)   | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) (1 visit per year) |
| • Hearing aids (\$2,500 per year)          |                                                      |                                               |
| • Infertility treatment (\$5,000 per year) |                                                      |                                               |

**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](http://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](http://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](http://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 5101 South Commerce Drive, 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](http://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.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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> | \$2,250 |
| ■ <u>Specialist</u> <u>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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,250        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$2,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,420</b> |

### 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> | \$2,250 |
| ■ <u>Specialist</u> <u>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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,250        |
| <u>Copayments</u>                 | \$500          |
| <u>Coinsurance</u>                | \$80           |
| What isn't covered                |                |
| Limits or exclusions              | \$70           |
| <b>The total Joe would pay is</b> | <b>\$2,900</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,250 |
| ■ <u>Specialist</u> <u>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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,250        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,350</b> |

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