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: **$2,250 single (employee only coverage) / $4,500 family (two party or family coverage) for policy period** For non-participating providers: **$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 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. Certain prescription drugs and 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: **$5,000 person / $10,000 family** For non-participating providers: **$6,500 person / $13,000 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?	Premiums, balance-billed charges, health care this plan doesn't cover, certain specialty pharmacy drugs, 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% coinsurance	40% coinsurance	——————none——————
	Specialist visit	20% coinsurance	40% coinsurance	——————none——————
	Preventive care/screening/immunization	No charge; deductible 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 preventive. 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)	20% coinsurance/ office visit 20% coinsurance/ outpatient visit 20% coinsurance/ inpatient services	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Requires preauthorization

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.emihealth.com.	Generic drugs	$7 copay/ prescription Retail $7 copay/ prescription Mail Order	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay. 90-day supply available at Costco, Sam's Club, and Walmart and is subject to 3x the retail copay amount. Deductible waived for medications on the Exclusive Maintenance Drug list found at http://emihealth.com/pdf/Exclusive.pdf
	Preferred brand drugs	$21 copay/ prescription Retail $42 copay/ prescription Mail Order	Not covered	
	Non-preferred brand drugs	$42 copay/ prescription Retail $126 copay/ prescription Mail Order	Not covered	
	Specialty drugs	Generic - $100 copay/ prescription Preferred - $100 copay/ prescription Non-Preferred - $100 copay/ prescription	Not covered	Covers up to a 90-day supply (mail order prescription) per copay. The cost of certain drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards your out-of-pocket limit. See **http://emihealth.com/pdf/saveon.pdf** for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance for ambulatory surgical center; 20% coinsurance for all other facilities	40% coinsurance	Some procedures require preauthorization
	Physician/surgeon fees	5% coinsurance for ambulatory surgical center physicians; 20% coinsurance for all other physicians	40% coinsurance	——————————none——————————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	——————————none——————————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————————none——————————
	Urgent care	20% coinsurance	40% coinsurance	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Requires preauthorization
	Physician/surgeon fee	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	20% coinsurance office visit and other outpatient services	40% coinsurance	Medications for substance abuse not covered
	Inpatient services	20% coinsurance	40% coinsurance	Requires preauthorization
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	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	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage limited to 60 outpatient visits per injury/illness and 40 inpatient days per policy period.
	Habilitation services	20% coinsurance	40% coinsurance	Neurodevelopmental therapy coverage is available for those ages birth thru 6 and is limited to 40 outpatient visits per policy period.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage limited to 30 days per policy period. Admission must be within 5 days of a discharge from Hospital Confinement.
	Durable medical equipment	20% coinsurance	40% coinsurance	Requires preauthorization
	Hospice services	20% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	Routine: No charge; deductible does not apply	Routine: Not covered	Limited to one preventive visit per policy period.
		Non-routine: 20% coinsurance	Non-routine: 40% coinsurance	——————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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care
- 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)
- Hearing aids ($2,500 per year)
- Infertility treatment ($5,000 per year)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (1 visit 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**, or for plans subect 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 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**.

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.

About these Coverage Examples:

This is not a cost estimator. Treaments 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	**$2,250**
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	$2,250
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,420**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$2,250**
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	$2,250
Copayments	$500
Coinsurance	$80
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$2,900**

Mia's Simple Fracture

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

The plan's overall deductible	**$2,250**
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	$2,250
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,350**

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