**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:<br>**$1,500 person / $3,000 family for calendar year**<br>For non-participating providers:<br>**$3,000 person / $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 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, prescription drugs, and office visits 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out–of–pocket limit for this plan?** | For participating providers:<br>**$6,000 person / $12,000 family**<br>For non-participating providers:<br>**$12,000 person / $24,000 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, Additional Benefits, 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 | $25 copay/ visit; deductible does not apply | 40% coinsurance | ——————none—————— |
| | Specialist visit | $50 copay/ visit; deductible does not apply | 40% coinsurance | ——————none—————— |
| | Preventive care/screening/immunization | No charge; deductible 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 preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge/ office visit; deductible does not apply<br>No charge/ outpatient visit; deductible does not apply<br>20% coinsurance/ inpatient services | 40% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.emihealth.com. | Generic drugs | $10 copay/ prescription Retail<br>$20 copay/ prescription Mail Order | Not covered | Up to a 30-day supply (retail prescription) per copay; 31-90 day supply (mail order prescription) per copay |
| | Preferred brand drugs | $35 copay/ prescription Retail<br>$70 copay/ prescription Mail Order | Not covered | Up to a 30-day supply (retail prescription) per copay; 31-90 day supply (mail order prescription) per copay |
| | Non-preferred brand drugs | 50% coinsurance Retail<br>50% coinsurance Mail Order | Not covered | Up to a 30-day supply (retail prescription) per copay; 31-90 day supply (mail order prescription) per copay |
| | Specialty drugs | 25% coinsurance ($250 maximum copay/ prescription) | Not covered | Covers 31-90 day supply (mail order prescription) per copay |

| 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% coinsurance | 40% coinsurance | Some procedures require preauthorization |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | $250 copay/ visit; deductible does not apply | $250 copay/ visit; deductible does not apply | ——————none—————— |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ——————none—————— |
| | Urgent care | $50 copay/ visit; deductible does not apply | 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—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/ office visit; deductible does not apply and 20% coinsurance 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 to certain 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 | |

| 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 help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | ——————————none—————————— |
| | Rehabilitation services | $25 copay/ office and outpatient visit; deductible does not apply and 20% coinsurance other inpatient services | 40% coinsurance | Coverage limited to 20 outpatient visits and 40 inpatient days per Year. |
| | Habilitation services | Not covered | Not covered | ——————————N/A—————————— |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Coverage limited to 30 days per Year. 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 Year. |
| | | Non-routine: $50 copay/ visit; deductible does not apply | 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 (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Habilitation services | • Private-duty nursing |
| • Bariatric surgery | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Infertility treatment | • Weight loss programs |
| • Dental care (Adult) | • Long-term care | |

| 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.) | | |
|---|---|---|
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |

**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 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.** 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 hopital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$50** |
| **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** | **$12,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $30 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,590** |

### Managing Joe's type 2 Diabetes

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$50** |
| **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** | **$7,400** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,400 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| **The total Joe would pay is** | **$1,800** |

### Mia's Simple Fracture

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$50** |
| **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** | **$1,900** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,400** |

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