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: **$3,000 person / $6,000 family for calendar year** For non-participating providers: **$6,000 person / $12,000 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: **$5,000 person / $10,000 family** For non-participating providers: **$10,000 person / $20,000 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	$30 copay/ visit; deductible does not apply	40% coinsurance	none
	Specialist visit	$60 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 needed 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 No charge/ outpatient visit; deductible does not apply No charge after deductible/ inpatient services	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No charge after deductible	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.mysmithrx.com.	Generic drugs	$15 copay/ prescription Retail $38 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
	Preferred brand drugs	$35 copay/ prescription Retail $88 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
	Non-preferred brand drugs	$70 copay/ prescription Retail $175 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
	Specialty drugs	25% coinsurance ($250 maximum copay/ prescription)	Not covered	Covers up to a 90-day supply (mail order prescription) per copay
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	40% coinsurance	Some procedures require preauthorization
	Physician/surgeon fees	No charge after deductible	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	$75 copay/ visit; deductible does not apply	40% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	40% coinsurance	Requires preauthorization
	Physician/surgeon fee	No charge after deductible	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	$30 copay/ office visit; deductible does not apply and no charge after deductible other outpatient services	40% coinsurance	Medications for substance abuse not covered
	Inpatient services	No charge after deductible	40% coinsurance	Requires preauthorization
If you are pregnant	Office visits	No charge after deductible	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	No charge after deductible	40% coinsurance	
	Childbirth/delivery facility services	No charge after deductible	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	40% coinsurance	——————none——————
	Rehabilitation services	$30 copay/ office and outpatient visit; deductible does not apply and no charge after deductible other inpatient services	40% coinsurance	Coverage limited to 20 outpatient visits per injury/illness and 40 inpatient days per Year.
	Habilitation services	Not covered	Not covered	——————N/A——————
	Skilled nursing care	No charge after deductible	40% coinsurance	Coverage limited to 30 days per Year. Admission must be within 5 days of a discharge from Hospital Confinement.
	Durable medical equipment	No charge after deductible	40% coinsurance	Requires preauthorization
	Hospice services	No charge after deductible	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: $60 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 (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)
- Habilitation services
- Infertility treatment
- 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
- Hearing aids
- 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 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	**$3,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$3,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$3,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,470**

Mia's Simple Fracture

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

The plan's overall deductible	**$3,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$1,500
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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