



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 <u>deductible</u>?	For <u>participating providers</u> : \$0 For <u>non-participating providers</u> : \$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u>?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u>?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u>?	Yes. See www.emihealth.com 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 **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> / visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
	<u>Specialist</u> visit	\$50 <u>copay</u> / visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	Coverage is limited to one visit per Year for some services. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services 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)	\$50 <u>copay</u> / office or outpatient visit for the first 3 visits per year, then not covered Inpatient not covered	Not covered	Coverage is limited to three visits per Year
	Imaging (CT/PET scans, MRIs)	\$250 <u>copay</u> for the first visit per year, then not covered	Not covered	Coverage is limited to one visit per Year. Requires <u>preauthorization</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.mysmithrx.com .	Generic drugs	ACA <u>Preventive Care</u> Mandates - No charge All Others - 10% <u>coinsurance</u>	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>
	Preferred brand drugs	ACA <u>Preventive Care</u> Mandates - No charge All Others - 50% <u>coinsurance</u>	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>
	Non-preferred brand drugs	ACA <u>Preventive Care</u> Mandates - No charge All Others - Not covered	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>
	<u>Specialty drugs</u>	Not covered	Not covered	—————N/A—————

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)	Not covered	Not covered	_____N/A_____
	Physician/surgeon fees	Not covered	Not covered	_____N/A_____
If you need immediate medical attention	<u>Emergency room care</u>	Not covered	Not covered	_____N/A_____
	<u>Emergency medical transportation</u>	Not covered	Not covered	_____N/A_____
	<u>Urgent care</u>	\$50 <u>copay</u> / visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	_____N/A_____
	Physician/surgeon fee	Not covered	Not covered	_____N/A_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	_____N/A_____
	Inpatient services	Not covered	Not covered	_____N/A_____
If you are pregnant	Office visits	Not covered	Not covered	Cost sharing does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not covered	Not covered	_____N/A_____
	<u>Rehabilitation services</u>	Not covered	Not covered	_____N/A_____
	<u>Habilitation services</u>	Not covered	Not covered	_____N/A_____
	<u>Skilled nursing care</u>	Not covered	Not covered	_____N/A_____
	<u>Durable medical equipment</u>	Not covered	Not covered	_____N/A_____
	<u>Hospice services</u>	Not covered	Not covered	_____N/A_____

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating <u>Provider</u> (You will pay the least)	Non-Participating <u>Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Routine: No charge	Routine: Not covered	Limited to one <u>preventive</u> visit per Year.
		Non-routine: Not covered	Non-routine: Not covered	—————N/A—————
	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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- 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 subject to ERISA: the Department of Labor's Employee Benefits Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EMI Health at 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? No.

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.

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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>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$11,300
The total Peg would pay is	\$11,500

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>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$1,300
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,800

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$2,600
The total Mia would pay is	\$2,700

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