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: **$0** For non-participating providers: **$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out–of–pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
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 copay/ visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
	Specialist visit	$50 copay/ visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
	Preventive care/screening/immunization	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 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)	$50 copay/ 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 copay for the first visit per year, then not covered	Not covered	Coverage is limited to one visit per Year. Requires preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mysmithrx.com.	Generic drugs	ACA Preventive Care Mandates - No charge All Others - 10% coinsurance	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	ACA Preventive Care Mandates - No charge All Others - 50% coinsurance	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	ACA Preventive Care Mandates - No charge All Others - Not covered	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	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	Emergency room care	Not covered	Not covered	——————N/A——————
	Emergency medical transportation	Not covered	Not covered	——————N/A——————
	Urgent care	$50 copay/ 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 preventive services. 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	Home health care	Not covered	Not covered	——————N/A——————
	Rehabilitation services	Not covered	Not covered	——————N/A——————
	Habilitation services	Not covered	Not covered	——————N/A——————
	Skilled nursing care	Not covered	Not covered	——————N/A——————
	Durable medical equipment	Not covered	Not covered	——————N/A——————
	Hospice services	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 your child needs dental or eye care	Children's eye exam	Routine: No charge	Routine: Not covered	Limited to one preventive 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 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? **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.

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	**$0**
Specialist copayment	**$50**
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	$0
Copayments	$200
Coinsurance	$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 plan's overall deductible	**$0**
Specialist copayment	**$50**
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	$300
Coinsurance	$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 plan's overall deductible	**$0**
Specialist copayment	**$50**
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	$0
Copayments	$100
Coinsurance	$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.