EMI HEALTH™

Administered by Educators Mutual Insurance Association
EMI Health Customer Service 801-262-7475 or 1-800-662-5851
Self Funded Employee Medical Benefit Plan

All services are subject to the EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Maximum Allowable Charge.

EMIA Pool **September 01, 2019 - August 31, 2020** **PHD2700 QHDHP**	**Care Plus**	
	Participating Provider Option	**Non-Participating Provider Option**
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year)	$3,500 / $7,000	$5,000 / $10,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	$2,700 / $5,400	$4,000 / $8,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic is available, member pays the copay plus the difference between the generic and the brand price)	**YOU PAY**	
Participating Pharmacy (30 day supply)	♦Generic - 10% ♦Preferred - 30% ♦Non-Preferred - 50%	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	♦Generic - 10% ♦Preferred - 30% ♦Non-Preferred - 50%	
PREVENTIVE SERVICES	**YOU PAY**	
Routine Physical Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Gynecological Exam (1 visit per Year)	Covered 100%	Not Covered
Family History Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Immunizations	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Hearing Exam (1 visit per Year)	Covered 100%	Not Covered
PHYSICIAN & PROFESSIONAL SERVICES	**YOU PAY**	
Physician Office Visits (primary care)	♦10%	♦40%
Physician Office Visits (secondary care)	♦10%	♦40%
Physician Office Visits (after hours)	♦10%	♦40%
Physician Visits (Inpatient)	♦10%	♦40%
Physician Visits (Outpatient)	♦10%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦10%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	♦10%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦10%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦10%	♦40%
Injections (office)	♦10%	♦40%
Surgery (office)	♦10%	♦40%
Surgery (Inpatient)	♦10%	♦40%
Surgery (Outpatient)	♦10%	♦40%
Anesthesiology (office)	♦10%	♦40%
Anesthesiology (Inpatient)	♦10%	♦40%
Anesthesiology (Outpatient)	♦10%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦10%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦10%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year)	♦10%	♦40%
Chiropractic Therapy (20 visits per Year)	♦10%	♦40%
Allergy Testing	♦10%	♦40%

EMIA Pool September 01, 2019 - August 31, 2020 PHD2700 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	♦10%	♦40%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦10%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦10%	♦40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦10%	♦40%
Medical/Surgical Care (Outpatient)	♦10%	♦40%
Emergency Room (ER)	♦10%	♦10%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦10%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦10%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦10%	♦40%
Newborn	♦10%	♦40%
InstaCare/Urgent Care Clinic	♦10%	♦40%
Eligible Preventive Services	Covered 100%	Not Covered
REHABILITATION THERAPY BENEFIT	**YOU PAY**	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	♦10%	♦40%
ACCIDENT AND LIFE THREATENING CONDITION	**YOU PAY**	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit to the Maximum Allowable Charge
Ambulance Land/Air (Accident & Life-threatening)	♦10%	
Orthodontic Injury Treatment	♦10%	
Dental Injury Treatment	♦10%	
TRANSPLANT BENEFIT	**YOU PAY**	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	**YOU PAY**	
Diabetic Testing Supplies (90 day supply)	♦30%	♦40%
Medical Supplies	♦10%	♦40%
Medical Supplies (office)	♦10%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦10%	♦40%
Orthotic Supplies (foot inserts & arch supports)	Not Covered	Not Covered
Growth Hormone	Not Covered	Not Covered
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Facility	♦10%	♦40%
Inpatient Physician Visits	♦10%	♦40%
Residential Treatment (30 days per year)	♦10%	♦40%
Outpatient Facility	♦10%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦10%	♦40%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN)	♦10%	Not Covered
Initial assessment and diagnosis of Primary Infertility	Not Covered	Not Covered
Reduction Mammoplasty	♦20%	Not Covered
Autism Applied Behavior Analysis (Ages 2 thru 9, up to 600 hours per Year)	♦10%	♦40%

Services designated ♦ are subject to first dollar Medical Deductible

Services designated *, premiums, balance-billed charges, charges for services this Plan doesn't cover, amounts in excess of benefit limits, and penalties for failure to obtain Preauthorization, do not accumulate toward your Out-of-pocket Maximum.

PROVIDER NETWORK	
Utah	EMI Health Care Plus
Outside of Utah	Cigna PPO

PLEASE NOTE: This is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan document and in the Summary Plan Description (SPD)/handbook of the Plan. Any discrepancies between this summary, the SPD/handbook, and the Plan document are resolved in favor of the Plan document. For more information, including Preauthorization, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.

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: **$2,700 person / $5,400 family for policy period** For non-participating providers: **$4,000 person / $8,000 family 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 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 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: **$3,500 person / $7,000 family** For non-participating providers: **$5,000 person / $10,000 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, 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	10% coinsurance	40% coinsurance	——————none——————
	Specialist visit	10% 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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance/ office visit 10% coinsurance/ outpatient visit 10% coinsurance/ inpatient services	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emihealth.com.	Generic drugs	10% coinsurance Retail 10% coinsurance 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	30% coinsurance Retail 30% coinsurance 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 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	30% coinsurance Mail Order	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)	10% coinsurance	40% coinsurance	Some procedures require preauthorization
	Physician/surgeon fees	10% coinsurance	40% coinsurance	——————————none——————————
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	——————————none——————————
	Emergency medical transportation	10% coinsurance	10% coinsurance	——————————none——————————
	Urgent care	10% coinsurance	40% coinsurance	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Requires preauthorization
	Physician/surgeon fee	10% coinsurance	40% coinsurance	——————————none——————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance office visit and other outpatient services	40% coinsurance	Medications for substance abuse not covered. Residential treatment coverage is limited to 30 days per policy period.
	Inpatient services	10% coinsurance	40% coinsurance	Requires preauthorization
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	——————————none——————————
	Rehabilitation services	10% coinsurance	40% coinsurance	Coverage limited to 20 outpatient visits and 40 inpatient days per policy period.
	Habilitation services	Not covered	Not covered	——————————N/A——————————
	Skilled nursing care	10% 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	10% coinsurance	40% coinsurance	Requires preauthorization
	Hospice services	10% 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 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: 10% 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 (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 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.**

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	**$2,700**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$2,700
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$2,700**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$2,700
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$3,600**

Mia's Simple Fracture

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

The plan's overall deductible	**$2,700**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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