



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<br>September 01, 2022 - August 31, 2023<br>PHD2800 QHDHP   | Care Plus  |                                      |
|--|--|--------------------------------------|
|  | Participating<br>Provider Option                           | Non-Participating<br>Provider Option |
| <b>GENERAL INFORMATION</b>   | <b>YOU PAY</b>   |                                      |
| 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 ♦   | \$2,800 / \$5,600  | \$4,000 / \$8,000                    |
| Non-Preauthorization Patient Penalty   | Not Applicable   | 50% Reduction in Benefits            |
| Non-Preauthorization Provider Sanction   | 50% Reduction in Payment                                   | Not Applicable                       |
| <b>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)</b> | <b>YOU PAY</b>   |                                      |
| Participating Pharmacy (30 day supply)   | ♦Generic - 10%<br>♦Preferred - 30%<br>♦Non-Preferred - 50% |                                      |
| Non-Participating Pharmacy   | Not Covered  |                                      |
| Mail Order (90 day supply)   | ♦Generic - 10%<br>♦Preferred - 30%<br>♦Non-Preferred - 50% |                                      |
| Specialty Pharmacy SaveOnSP Program 1-800-683-1074<br><a href="http://emihealth.com/pdf/saveon.pdf">http://emihealth.com/pdf/saveon.pdf</a>                            | Must enroll to receive:<br>*\$0 Copay                      |                                      |
| <b>PREVENTIVE SERVICES</b>   | <b>YOU PAY</b>   |                                      |
| 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                          |
| <b>PHYSICIAN &amp; PROFESSIONAL SERVICES</b>   | <b>YOU PAY</b>   |                                      |
| 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 per injury/illness)                                      | ♦10%   | ♦40%                                 |
| Chiropractic Therapy (20 visits per Year)  | ♦10%   | ♦40%                                 |
| Allergy Testing  | ♦10%   | ♦40%                                 |

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|--|---|--|
|  | Participating<br>Provider Option                              | Non-Participating<br>Provider Option                               |
| Allergy Treatment/Serum  | ◆10%  | ◆40%   |
| <b>HOSPITAL/FACILITY BENEFITS</b><br>(Physician & Professional Services are not included in this section.)   | <b>YOU PAY</b>  |  |
| 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  |
| <b>REHABILITATION THERAPY BENEFIT</b>  | <b>YOU PAY</b>  |  |
| Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)  | ◆10%  | ◆40%   |
| <b>ACCIDENT AND LIFE THREATENING CONDITION</b>   | <b>YOU PAY</b>  |  |
| 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%  |  |
| <b>TRANSPLANT BENEFIT</b>  | <b>YOU PAY</b>  |  |
| Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney  | Covered as any other condition                                | Not Covered  |
| <b>MEDICAL SUPPLIES &amp; EQUIPMENT</b>  | <b>YOU PAY</b>  |  |
| 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%   |
| Hearing Aids (\$2,500 per Year)  | ◆10%  | ◆40%   |
| Orthotic Supplies (foot inserts & arch supports)   | Not Covered   | Not Covered  |
| Growth Hormone   | Not Covered   | Not Covered  |
| <b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>  | <b>YOU PAY</b>  |  |
| Inpatient Facility   | ◆10%  | ◆40%   |
| Inpatient Physician Visits   | ◆10%  | ◆40%   |
| Residential Treatment (30 days per Year)   | ◆10%  | ◆40%   |
| Outpatient Facility  | ◆10%  | ◆40%   |
| Physician Office Visits<br>Psychologist / LCSW / APRN / Psychiatrist   | ◆10%  | ◆40%   |
| <b>ADDITIONAL BENEFITS</b>   | <b>YOU PAY</b>  |  |
| Adoption Indemnity Benefit   | The Plan pays a maximum of \$4,000 towards adoption expenses. |  |
| TMJ Syndrome diagnosis & non-surgical treatment  | ◆10%  | Not Covered  |
| Orthognathic/Mandibular Osteotomy  | ◆10%  | Not Covered  |
| Total Parenteral Nutrition (TPN)   | ◆10%  | Not Covered  |
| Initial assessment and diagnosis of Primary Infertility  | ◆10%  | Not Covered  |
| Reduction Mammoplasty  | ◆10%  | Not Covered  |
| Autism Applied Behavior Analysis   | ◆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. |   |  |
| <b>PROVIDER NETWORK</b>  |   |  |
| 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:  |
|--|--|--|
| <b>What is the overall deductible?</b>                             | For <u>participating providers</u> :<br><b>\$2,800 person / \$5,600 family for policy period</b><br>For <u>non-participating providers</u> :<br><b>\$4,000 person / \$8,000 family for policy period</b> | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .  | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| <b>Are there other deductibles for specific services?</b>          | No.  | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <u>participating providers</u> :<br><b>\$3,500 person / \$7,000 family</b><br>For <u>non-participating providers</u> :<br><b>\$5,000 person / \$10,000 family</b>                                    | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , balance-billed charges, health care this <u>plan</u> doesn't cover, certain <u>specialty pharmacy drugs</u> , and penalties for failure to obtain <u>preauthorization</u> for services | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.emihealth.com">www.emihealth.com</a> 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. |
| <b>Do you need a referral to see a specialist?</b>                 | 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 <u>Provider</u> (You will pay the least) | Non-Participating <u>Provider</u> (You will pay the most) |   |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 10% <u>coinsurance</u>                                 | 40% <u>coinsurance</u>                                    | —————none—————  |
|   | <u>Specialist</u> visit                          | 10% <u>coinsurance</u>                                 | 40% <u>coinsurance</u>                                    | —————none—————  |
|   | <u>Preventive care/screening/immunization</u>    | No charge; <u>deductible</u> 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 <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)       | 10% <u>coinsurance</u> / office visit                  | 40% <u>coinsurance</u>                                    | —————none—————  |
|   |  | 10% <u>coinsurance</u> / outpatient visit              |   |   |
|   | 10% <u>coinsurance</u> / inpatient services      | 10% <u>coinsurance</u>                                 | 40% <u>coinsurance</u>                                    | —————none—————  |
|   | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u>                                 | 40% <u>coinsurance</u>                                    | —————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) |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.emihealth.com">www.emihealth.com</a> . | Generic drugs                                  | 10% <u>coinsurance</u> Retail<br>10% <u>coinsurance</u> Mail Order | Not covered  | Up to a 30-day supply (retail prescription) per <u>copay</u> ; 31-90 day supply (mail order prescription) per <u>copay</u>  |
|   | Preferred brand drugs                          | 30% <u>coinsurance</u> Retail<br>30% <u>coinsurance</u> Mail Order | Not covered  | Up to a 30-day supply (retail prescription) per <u>copay</u> ; 31-90 day supply (mail order prescription) per <u>copay</u>  |
|   | Non-preferred brand drugs                      | 50% <u>coinsurance</u> Retail<br>50% <u>coinsurance</u> Mail Order | Not covered  | Up to a 30-day supply (retail prescription) per <u>copay</u> ; 31-90 day supply (mail order prescription) per <u>copay</u>  |
|   | <u>Specialty drugs</u>                         | 30% <u>coinsurance</u> Mail Order                                  | Not covered  | Covers 31-90 day supply (mail order prescription) per <u>copay</u> . The cost of certain drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards your <u>out-of-pocket limit</u> . See <a href="http://emihealth.com/pdf/saveon.pdf">http://emihealth.com/pdf/saveon.pdf</a> for details. |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>   | 40% <u>coinsurance</u>                             | Some procedures require <u>preauthorization</u>   |
|   | Physician/surgeon fees                         | 10% <u>coinsurance</u>   | 40% <u>coinsurance</u>                             | —————none—————  |
| <b>If you need immediate medical attention</b>  | <u>Emergency room care</u>                     | 10% <u>coinsurance</u>   | 10% <u>coinsurance</u>                             | —————none—————  |
|   | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u>   | 10% <u>coinsurance</u>                             | —————none—————  |
|   | <u>Urgent care</u>                             | 10% <u>coinsurance</u>   | 40% <u>coinsurance</u>                             | —————none—————  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)             | 10% <u>coinsurance</u>   | 40% <u>coinsurance</u>                             | Requires <u>preauthorization</u>  |
|   | Physician/surgeon fee                          | 10% <u>coinsurance</u>   | 40% <u>coinsurance</u>                             | —————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                       | 10% <u>coinsurance</u> office visit and other outpatient services | 40% <u>coinsurance</u>                             | Medications for substance abuse not covered. Residential treatment coverage is limited to 30 days per policy period.   |
|   | Inpatient services                        | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             | Requires <u>preauthorization</u>   |
| If you are pregnant   | Office visits                             | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             | Cost sharing does not apply for <u>preventive</u> services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             |  |
|   | Childbirth/delivery facility services     | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             |  |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             | —————none—————   |
|   | <u>Rehabilitation services</u>            | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             | Coverage limited to 20 outpatient visits and 40 inpatient days per policy period.  |
|   | <u>Habilitation services</u>              | Not covered   | Not covered  | —————N/A—————  |
|   | <u>Skilled nursing care</u>               | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             | Coverage limited to 30 days per policy period. Admission must be within 5 days of a discharge from Hospital Confinement.   |
|   | <u>Durable medical equipment</u>          | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             | Requires <u>preauthorization</u>   |
|   | <u>Hospice services</u>                   | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>                             | —————none—————   |
| If your child needs dental or eye care                                    | Children's eye exam                       | Routine: No charge; <u>deductible</u> does not apply              | Routine: Not covered                               | Limited to one <u>preventive</u> visit per policy period.  |
|   |   | Non-routine: 10% <u>coinsurance</u>                               | Non-routine: 40% <u>coinsurance</u>                | —————none—————   |
|   | Children's glasses                        | Not covered   | Not covered  | —————N/A—————  |
|   | Children's dental check-up                | Not covered   | Not covered  | —————N/A—————  |

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Habilitation services</li><li>• Infertility treatment</li><li>• Long-term care</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|--|--|---|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing Aids (\$2,500 per year)</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li></ul> |
|---|--|--|

**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](http://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](http://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](http://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](http://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.*

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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> | \$2,800 |
| ■ <u>Specialist coinsurance</u>               | 10%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 10%     |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$700          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,560</b> |

### 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> | \$2,800 |
| ■ <u>Specialist coinsurance</u>               | 10%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 10%     |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$700          |
| What isn't covered                |                |
| Limits or exclusions              | \$70           |
| <b>The total Joe would pay is</b> | <b>\$3,570</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,800 |
| ■ <u>Specialist coinsurance</u>               | 10%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 10%     |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

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