



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, 2022 - August 31, 2023 PHD3500 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)	\$5,000 / \$10,000	\$6,000 / \$12,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	\$3,500 / \$7,000	\$5,000 / \$10,000
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%	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	Must enroll to receive: *\$0 Copay	
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)	♦20%	♦40%
Physician Office Visits (secondary care)	♦20%	♦40%
Physician Office Visits (after hours)	♦20%	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦20%	♦40%
Injections (office)	♦20%	♦40%
Surgery (office)	♦20%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Anesthesiology (office)	♦20%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness)	♦20%	♦40%
Chiropractic Therapy (20 visits per Year)	♦20%	♦40%
Allergy Testing	♦20%	♦40%

EMIA Pool September 01, 2022 - August 31, 2023 PHD3500 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	◆20%	◆40%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆20%	◆40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆20%	◆40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	◆20%	◆40%
Medical/Surgical Care (Outpatient)	◆20%	◆40%
Emergency Room (ER)	◆20%	◆20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	◆20%	◆40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆20%	◆40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	◆20%	◆40%
Newborn	◆20%	◆40%
InstaCare/Urgent Care Clinic	◆20%	◆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)	◆20%	◆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)	◆20%	
Orthodontic Injury Treatment	◆20%	
Dental Injury Treatment	◆20%	
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	◆20%	◆40%
Medical Supplies (office)	◆20%	◆40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	◆20%	◆40%
Hearing Aids (\$2,500 per Year)	◆20%	◆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	◆20%	◆40%
Inpatient Physician Visits	◆20%	◆40%
Residential Treatment (30 days per Year)	◆20%	◆40%
Outpatient Facility	◆20%	◆40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	◆20%	◆40%
ADDITIONAL BENEFITS	YOU PAY	
Adoption Indemnity Benefit	The Plan pays a maximum of \$4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment	◆20%	Not Covered
Orthognathic/Mandibular Osteotomy	◆20%	Not Covered
Total Parenteral Nutrition (TPN)	◆20%	Not Covered
Initial assessment and diagnosis of Primary Infertility	◆20%	Not Covered
Reduction Mammoplasty	◆20%	Not Covered
Autism Applied Behavior Analysis	◆20%	◆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: \$3,500 person / \$7,000 family for policy period For non-participating providers: \$5,000 person / \$10,000 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: \$5,000 person / \$10,000 family For non-participating providers: \$6,000 person / \$12,000 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, certain specialty pharmacy drugs, 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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<u>Specialist</u> visit	20% <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)	20% <u>coinsurance</u> / office visit	40% <u>coinsurance</u>	—————none—————
		20% <u>coinsurance</u> / outpatient visit		
	20% <u>coinsurance</u> / inpatient services			
	Imaging (CT/PET scans, MRIs)	20% <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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.emihealth.com .	Generic drugs	10% <u>coinsurance</u> Retail 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 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 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 http://emihealth.com/pdf/saveon.pdf for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Some procedures require <u>preauthorization</u>
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Requires <u>preauthorization</u>
	Physician/surgeon fee	20% <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	20% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Requires <u>preauthorization</u>
If you are pregnant	Office visits	20% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<u>Rehabilitation services</u>	20% <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>	20% <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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Requires <u>preauthorization</u>
	<u>Hospice services</u>	20% <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: 20% <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">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Habilitation services• Infertility treatment• Long-term care | <ul style="list-style-type: none">• 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.)

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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>	\$3,500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

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>	\$3,500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Joe would pay is	\$4,170

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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:

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

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