EMI Health : EMIA Pool PHD0

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 9/1/2014-8/31/2015

Coverage for: Employee + Dependents |

Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-800-662-5851. The Uniform Glossary can be accessed at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: **$2,500 person / $5,000 family for policy period** Doesn't apply to preventive care. For non-participating providers: **$2,750 person / $5,500 family for policy period**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	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.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers: **$2,500 person / $5,000 family** For non-participating providers: **$4,000 person / $8,000 family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, mental health and penalties for failure to obtain pre-authorization for services	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call 1-800-662-5851 or visit us at **www.emihealth.com**.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov**.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.emihealth.com **or call 1-800-662-5851** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	40% coinsurance	————————none————————
	Specialist visit	No charge	40% coinsurance	————————none————————
	Other practitioner office visit	No charge for chiropractor	40% coinsurance for chiropractor	Coverage is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited to one visit per policy period for some services.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	No charge/ office visit No charge/ outpatient visit No charge/ inpatient services	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	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	No charge prescription Retail No charge prescription 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	No charge prescription Retail No charge prescription 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	No charge prescription Retail No charge prescription 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	No charge prescription Mail Order	Not covered	Covers 31-90 day supply (mail order prescription) per copay
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	Some procedures require preauthorization
	Physician/surgeon fees	No charge	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	No charge	No charge	——————none——————
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	No charge	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% coinsurance	Requires preauthorization
	Physician/surgeon fee	No charge	40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	Coverage limited to 15 outpatient visits per policy period, 1 visit per day.
	Mental/Behavioral health inpatient services	No charge	Not covered	Requires preauthorization. Coverage limited to 15 inpatient days per policy period.
	Substance use disorder outpatient services	No charge	Not covered	Medications for substance abuse not covered. Limited to 15 outpatient visits per policy period, 1 visit per day.
	Substance use disorder inpatient services	No charge	Not covered	Requires preauthorization. Coverage limited to 15 inpatient days per policy period.
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance	——————none——————
	Delivery and all inpatient services	No charge	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	————————none————————
	Rehabilitation services	No charge office or outpatient visit	40% coinsurance	Coverage limited to 20 outpatient visits and 40 inpatient days per policy period. Limits are combined with Habilitation services.
	Habilitation services	No charge office or outpatient visit	40% coinsurance	Coverage is limited to 20 outpatient visits and 40 inpatient days per policy period. Limits are combined with Rehabilitation services.
	Skilled nursing care	No charge	40% coinsurance	Coverage limited to 60 days per policy period. Admission must be within 5 days of a discharge from Hospital Confinement.
	Durable medical equipment	No charge	40% coinsurance	Must be preauthorized if more than $750
	Hospice service	No charge	40% coinsurance	————————none————————
If your child needs dental or eye care	Eye exam	Routine: No charge	Routine: Not covered	Limited to one preventive visit per policy period.
		Non-routine: No charge	Non-routine: 40% coinsurance	————————none————————
	Glasses	Not covered	Not covered	————————none————————
	Dental check-up	Not covered	Not covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-662-5851. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: EMI Health at 852 E. Arrowhead Lane, Murray Utah 84107, by phone at 801-662-5851 or toll free at 1-800-662-5851. Additionally, if the dispute is regarding a determination of medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of the healthcare service or treatment, you have the voluntary option to submit the adverse benefit determination for an independent review. You may obtain additional information about an independent review from the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, Utah 84114, by phone at 801-538-3077, or electronically at healthappeals.uid@utah.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,840
- **Patient pays:** $3,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory Tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,400
Copays	$0
Coinsurance	$0
Limits or exclusions	$300
Total	**$3,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,700
- **Patient pays:** $2,700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,700**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- The examples are for an individual with Employee Only coverage.
- Hospital charge for a baby may be subject to the applicable deductible, in which case the deductible for the baby will be included in the Deductible payment listed on the Example

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my future expenses?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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