

# Educators Mutual Insurance Association of Utah

Customer Service 262-7475 or 1-800-662-5851

Fully-Insured Employee Medical Benefit Plan - Underwritten by Educators Health Care

Administered by Educators Mutual Insurance Association of Utah

All services are subject to Educators Table of Allowances. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Table of Allowances.

Weber State University Summary of Benefits July 1, 2007 - June 30, 2008	Educators Care Plus	
	Participating Provider Option	Non-participating Provider Option
<b>GENERAL INFORMATION</b>	<b>YOU PAY</b>	
Lifetime Maximum Benefit	\$2,000,000	
Preexisting Condition Window Period	6 months prior	
Preexisting Condition Waiting Period	First 10 months of coverage / 18 months Late Enrollees	
Dependent Age Limit	26	
Coinsurance Maximum (Per Person/Family Per Plan Year - Separate from and not satisfied by the Mental Health or the Prescription Coinsurance Maximum)	\$1,200 / \$2,400	\$1,200 / \$2,400
First Dollar Deductible (Per Person/Family Per Plan Year - Separate from and not satisfied by Mental Health Deductible)	*\$400 / *\$1,200	*\$400 / *\$1,200
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
Non-Precertification EAP Penalty	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>	
Coinsurance Maximum (Per Family Per Plan Year)	*\$1,250	
Participating Pharmacy (30 day supply)	20% Generic (\$5 Min) / 25% Preferred (\$10 Min) / 35% Non-Preferred (\$20 Min)	
Non-Participating Pharmacy (30 day supply)	20% Generic (\$5 Min) / 25% Preferred (\$10 Min) / 35% Non-Preferred (\$20 Min)	
	Member pays in full at time of purchase, then files for reimbursement	
Significant Medication (during first 12 months after FDA approval)	*50%	
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	
Mail Order (90 day supply)	20% Generic (\$5 Min) / 25% Preferred (\$10 Min) / 35% Non-Preferred (\$20 Min)	
<b>HOSPITAL/FACILITY BENEFITS</b> (Physician and Professional Services are not included in this section.)	<b>YOU PAY</b>	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆ 5%	◆ 20%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆ 5%	◆ 20%
Skilled Nursing Facility (60 days per Confinement) (Admission must be within 5 days of discharge from Hospital Confinement)	◆ 5%	◆ 20%
Medical/Surgical Care (Outpatient)	◆ 5%	◆ 20%
Emergency Room (ER)	*\$100	*\$65 then 20%
Major Diagnostic Test (per test of \$300 or more)	◆ 5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Inpatient) (per test less than \$300)	5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Outpatient) (per test less than \$300)	5%	◆ 20%
InstaCare Clinic	*\$35	◆ 20%
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>	
Inpatient – physical, speech, occupational, cardiac or pulmonary (\$5,000 per person per Plan year)	◆ 5%	◆ 20%
<b>ACCIDENT AND LIFE THREATENING ILLNESS</b>	<b>YOU PAY</b>	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit subject to the Table of Allowance
Ambulance Land/Air (Accident & Life-threatening)	*\$65	
Orthodontic Injury Treatment (\$500 per occurrence)	◆ *50%	◆ *50%
Dental Injury Treatment	◆ 20%	◆ 20%

Services designated \* do not accumulate toward your Coinsurance Maximum

Services designated ◆ are subject to first dollar Deductible.

Weber State University Summary of Benefits July 1, 2007 - June 30, 2008	Educators Care Plus	
	Participating Provider Option	Non-participating Provider Option
<b>PHYSICIAN &amp; PROFESSIONAL SERVICES</b>	<b>YOU PAY</b>	
Physician Office Visits (primary care)	*\$20	◆ 20%
Physician Office Visits (secondary care)	*\$30	◆ 20%
Physician Office Visits (after hours)	*\$30	◆ 20%
Physician Visits (Inpatient)	◆ 5%	◆ 20%
Physician Visits (Outpatient)	Covered 100%	◆ 20%
Major Diagnostic Test (office) (per test of \$300 or more)	◆ 5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (office) (per test less than \$300)	Covered 100%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Inpatient) (per test less than \$300)	5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Outpatient) (per test less than \$300)	5%	◆ 20%
Radiology/Pathology (office)	Covered 100%	◆ 20%
Radiology/Pathology (Inpatient)	5%	◆ 20%
Radiology/Pathology (Outpatient)	5%	◆ 20%
Injections (with office visit)	Covered 100% (after copay)	◆ 20%
Surgery (office)	*\$20	◆ 20%
Surgery (Inpatient)	◆ 10%	◆ 20%
Surgery (Outpatient)	◆ 10%	◆ 20%
Anesthesiology (office)	Covered 100%	◆ 20%
Anesthesiology (Inpatient)	5%	◆ 20%
Anesthesiology (Outpatient)	5%	◆ 20%
Routine Prenatal & Delivery (Dependent maternity included)	5%	◆ 20%
Home Health Care (in lieu of Hospital)(for supplies, see Medical Supplies and Equipment)	◆ 5%	◆ 20%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac or pulmonary - 20 visits per Plan year - Preauthorization required after first 5 visits)	*\$20	◆ 20%
Chiropractic Therapy (20 visits per Plan year, Preauthorization required after first 5 visits)	*50% (CHP)	◆ *50%
Allergy/Serum	*\$15 per vial	◆ 20%
Allergy Injections (with office visit)	Covered 100% (after copay)	◆ 20%
<b>NEWBORN BENEFITS AT DELIVERY</b>	<b>YOU PAY</b>	
Medical/Surgical/Intensive Care/Newborn Complications (semi-private room)	5%	20%
Medical/Surgical/Intensive Care/Newborn Complications (Inpatient Ancillary)	5%	20%
Physician Visits (Inpatient)	5%	20%
Surgery (Inpatient)	10%	20%
Radiology/Pathology (Inpatient)	5%	20%
Anesthesiology (Inpatient)	5%	20%
<b>PREVENTIVE SERVICES</b>	<b>YOU PAY</b>	
Routine Physical Exam (1 visit per Plan Year)	Covered 100%	Not Covered
Routine Gynecological Exam (1 visit per Plan Year)	Covered 100%	Not Covered
Family History Exam (1 visit per Plan Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (per evaluation schedule)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Child Immunizations (per evaluation schedule)	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Plan Year)	*\$20	Not Covered
Routine Hearing Exam (1 visit per Plan Year)	*\$20	Not Covered
<b>TRANSPLANT BENEFIT (\$100,000 lifetime combined maximum)</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>	
Medical Supplies	◆ 20%	◆ 20%
Medical Supplies (office)	Covered 100%	◆ 20%
Durable Medical Equipment/Prosthesis	◆ 20%	◆ 20%
Orthotic Supplies (\$200 per Plan year)	◆ 20%	◆ 20%
Growth Hormone (\$8,000 per lifetime)	◆ 20%	◆ 20%

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Services designated ◆ are subject to first dollar Deductible.

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	Participating Provider Option	Non-participating Provider Option
<b>DENTAL BENEFITS</b>	<b>YOU PAY</b>	
Impacted Teeth/Cysts/Tumors	Covered on Dental Plan	
<b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>	<b>YOU PAY</b>	
Coinsurance Maximum (Per Person/Family Per Plan Year - Separate from and not satisfied by Medical Coinsurance Maximum)	\$1,200 / \$2,400	\$1,200 / \$2,400
First Dollar Deductible (Per Person/Family Per Plan Year - Separate from and not satisfied by Medical Deductible)	*\$400 / *\$1,200	*\$400 / *\$1,200
Inpatient Facility Semi-private Room	◆ *\$50 per day	◆ *\$50 per day then *50%
Inpatient Facility Ancillary	◆ 5%	◆ *50%
Inpatient Facility Physician Visits	◆ 5%	◆ *50%
Physician Office Visits Psychologist/Clinical Social Worker/APRN/Psychiatrist	*\$25	◆ *50%
<b>OTHER LIMITED BENEFITS</b>	<b>YOU PAY</b>	
Adoption Indemnity Benefit (\$4,000 per adoption)	◆ 5%	
TMJ Syndrome diagnosis & non-surgical treatment (\$500 per lifetime)	◆ *50%	◆ *50%
Orthognathic/Mandibular Osteotomy (\$2,500 per lifetime)	◆ *50%	◆ *50%
Total Parenteral Nutrition (\$10,000 per Plan year)	◆ *50%	◆ *50%
Significant Medication (during first 12 months after FDA approval)	*50%	◆ *50%
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	◆ *50%
Primary Infertility (\$1,500 per Plan year, \$5,000 per lifetime)	◆ *50%	Not Covered

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 Educators Customer Service Department.