



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, 2021 - August 31, 2022 PHD2800 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating 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% ♦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 <a href="http://emihealth.com/pdf/saveon.pdf">http://emihealth.com/pdf/saveon.pdf</a>	Must enroll to receive: *\$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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Allergy Treatment/Serum	◆10%	◆40%
<b>HOSPITAL/FACILITY BENEFITS</b> (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 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.