EMI HEALTH Smart Benefits

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 Table of Allowances. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Table of Allowances.

Southern Utah University #144 **351 W. University Blvd. , Cedar City, Utah 84720** **435-586-7754**	**Care Plus**	
July 01, 2013 - June 30, 2014 **Option 2 - $1,500 Ded**	**Participating Provider Option**	**Non-Participating Provider Option**
GENERAL INFORMATION	**YOU PAY**	
Preexisting Condition Window Period (Age 19 and above)	6 months prior	
Preexisting Condition Waiting Period (Age 19 and above)	First 8 months of coverage / 18 months Late Enrollees	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Coinsurance Maximum (Per Single/Family Per Year)	$3,000 / $5,000	$6,000 / $10,000
Medical Deductible (Per Single/Family Per Year). Please note ♦	$1,500 / $2,500	$3,000 / $5,000
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% ($250 Max) ♦Non-Preferred - 50% ($250 Max)	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	♦Generic - $20 ♦Preferred - 30% ($250 Max) ♦Non-Preferred - 50% ($250 Max)	
PREVENTIVE SERVICES	**YOU PAY**	
Routine Physical Exam (1 visit per Year)	Covered 100%	♦40%
Routine Gynecological Exam (1 visit per Year)	Covered 100%	♦40%
Family History Exam (1 visit per Year)	Covered 100%	♦40%
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	♦40%
Routine Well-Baby Exams	Covered 100%	♦40%
Covered Immunizations	Covered 100%	♦40%
Routine Vision Exam (1 visit per Year)	Covered 100%	♦40%
Routine Hearing Exam (1 visit per Year)	Covered 100%	♦40%
PHYSICIAN & PROFESSIONAL SERVICES	**YOU PAY**	
Physician Office Visits (primary care)	♦$40	♦40%
Physician Office Visits (secondary care)	♦$50	♦40%
Physician Office Visits (after hours)	♦$50	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (office)	♦Covered 100%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦20%	♦40%
Radiology/Pathology (office)	♦Covered 100%	♦40%
Radiology/Pathology (Inpatient)	♦20%	♦40%
Radiology/Pathology (Outpatient)	♦20%	♦40%
Injections (office)	♦Covered 100%	♦40%
Surgery (office)	♦Covered 100%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Anesthesiology (office)	♦Covered 100%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦40%
Home Health Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 30 visits per Year)	♦$50	♦40%

Southern Utah University #144 351 W. University Blvd. , Cedar City, Utah 84720 435-586-7754	Care Plus	
July 01, 2013 - June 30, 2014 Option 2 - $1,500 Ded	**Participating Provider Option**	**Non-Participating Provider Option**
Chiropractic Therapy (10 visits per Year)	♦$50 (CHP)	♦40%
Allergy Testing	♦20%	♦40%
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 (60 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 (30 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 subject to the Table of Allowance
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	♦20%	♦40%
Orthotic Supplies	♦20%	♦40%
Growth Hormone	♦20%	♦40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Facility Semi-private Room	♦20%	♦40%
Inpatient Facility Ancillary	♦20%	♦40%
Inpatient Facility Physician Visits	♦20%	♦40%
Physician Office Visits Psychologist / Clinical Social Worker / APRN / Psychiatrist	♦$50	♦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
Primary Infertility	♦20%	Not Covered
Reduction Mammoplasty	♦20%	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 EMI Health Customer Service Department.

Services designated * do not accumulate toward the applicable Coinsurance Maximum. Services designated ♦ are subject to first dollar Medical Deductible