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 **July 01, 2017 - June 30, 2018** **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 Single/Family Per Year)	$3,000 / $6,000	$6,000 / $12,000
Medical Deductible (Per Single/Family Per Year). Please note ♦	$1,500 / $3,000	$3,000 / $6,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
PRESCRIPTION DRUG BENEFITS - Administered by VRx (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% ($350 Max)	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	♦Generic - $20 ♦Preferred - 30% ($250 Max) ♦Non-Preferred - 50% ($350 Max)	
Specialty Drug	♦ Tier 1 - 15% ($200 Max) ♦ Tier 2 - 25% ($275 Max) ♦ Tier 3 - 40% ($400 Max) ♦ Tier 4 - Excluded Prescriptions	
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)	♦$35	♦40%
Physician Office Visits (secondary care)	♦$45	♦40%
Physician Office Visits (after hours)	♦$45	♦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)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦20%	♦40%
Radiology/Pathology (office)	♦20%	♦40%
Radiology/Pathology (Inpatient)	♦20%	♦40%
Radiology/Pathology (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 - 30 visits per Year)	♦$45	♦40%
Chiropractic Therapy (10 visits per Year)	♦$45	♦40%

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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
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 Services (non-residential)	♦20%	♦40%
Residential Treatment	Not Covered	Not Covered
Outpatient Services	♦20%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦$45	♦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	♦50%	Not Covered
Autism Applied Behavior Analysis (Ages 2 thru 9, up to 600 hours per Year)	♦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.

Single/Family note: The Single Deductible and Out-of-Pocket Maximum amounts apply only to those Covered Persons with single coverage. Covered Persons with family (two-party or more) coverage, must meet the Family Deductible and Out-of-Pocket Maximum amounts, either individually or accumulatively as a family.

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.