

# Educators Health Care

Administered by Educators Mutual Insurance Association

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

Fully Insured Employee Medical Benefit Plan

**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 #880 1016 University Circle, Ogden, UT 84408 801-626-6035	Educators Care Plus	
July 01, 2009 - June 30, 2010	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	
Benefit Accumulator Year	Contract	
Dependent Age Limit	26	
Coinsurance Maximum (Per Person/Family Per Year - Separate from and not satisfied by the Mental Health or Prescription Drug Coinsurance Maximum). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	\$1,500 / \$3,000	\$1,500 / \$3,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Mental Health or Prescription Drug Deductible). Please note ♦.	*\$600 / *\$1,800	*\$600 / *\$1,800
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>	
Prescription Drug Coinsurance Maximum (Per Person/Family Per Year - Separate from and not satisfied by the Medical or Mental Health Coinsurance Maximum). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	*\$1,250	
Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical or Mental Health Deductible). Please note ●.	*\$50 / *\$150	
Participating Pharmacy (30 day supply)	<ul style="list-style-type: none"> <li>● Generic - 20% (\$5 Min)</li> <li>● Preferred Brand - 25% (\$10 Min)</li> <li>● Non-Preferred Brand - 35% (\$20 Min)</li> </ul>	
Non-Participating Pharmacy (30 day supply) -- Member pays in full at time of purchase, then files for reimbursement	<ul style="list-style-type: none"> <li>● Generic - 20% (\$5 Min)</li> <li>● Preferred Brand - 25% (\$10 Min)</li> <li>● Non-Preferred Brand - 35% (\$20 Min)</li> </ul>	
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)	<ul style="list-style-type: none"> <li>● Generic - 20% (\$5 Min)</li> <li>● Preferred Brand - 25% (\$10 Min)</li> <li>● Non-Preferred Brand - 35% (\$20 Min)</li> </ul>	
<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%	♦30%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦10%	♦30%
Skilled Nursing Facility (60 days per Confinement) (Admission must be within 5 days of discharge from Hospital Confinement)	♦10%	♦30%
Medical/Surgical Care (Outpatient)	♦10%	♦30%
Emergency Room (ER)	*\$150	*♦\$250
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦10%	♦30%

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Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆10%	◆30%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	10%	◆30%
InstaCare/Urgent Care Clinic	*\$45	◆30%
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	◆10%	◆30%
<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 subject to the Table of Allowance
Ambulance Land/Air (Accident & Life-threatening)	*\$100	
Orthodontic Injury Treatment (\$500 maximum per occurrence)	◆50%	
Dental Injury Treatment	◆20%	
<b>PHYSICIAN &amp; PROFESSIONAL SERVICES</b>	<b>YOU PAY</b>	
Physician Office Visits (primary care)	*\$25	◆30%
Physician Office Visits (secondary care)	*\$35	◆30%
Physician Office Visits (after hours)	*\$35	◆30%
Physician Visits (Inpatient)	◆10%	◆30%
Physician Visits (Outpatient)	Covered 100%	◆30%
Major Diagnostic Test (office) (per test of \$300 or more)	◆10%	◆30%
Minor Diagnostic Test, X-ray, Lab (office) (per test less than \$300)	Covered 100%	◆30%
Minor Diagnostic Test, X-ray, Lab (Inpatient) (per test less than \$300)	◆10%	◆30%
Minor Diagnostic Test, X-ray, Lab (Outpatient) (per test less than \$300)	10%	◆30%
Radiology/Pathology (office)	Covered 100%	◆30%
Radiology/Pathology (Inpatient)	◆10%	◆30%
Radiology/Pathology (Outpatient)	10%	◆30%
Injections (with office visit)	Covered 100% (after copay)	◆30%
Surgery (office)	*\$25	◆30%
Surgery (Inpatient)	◆10%	◆30%
Surgery (Outpatient)	◆10%	◆30%
Anesthesiology (office)	Covered 100%	◆30%
Anesthesiology (Inpatient)	◆10%	◆30%
Anesthesiology (Outpatient)	10%	◆30%
Routine Prenatal & Delivery (Dependent maternity included)	10%	◆30%
Home Health Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	◆10%	◆30%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac or pulmonary - 20 visits per Year - Preauthorization required after first 5 visits)	*\$30	◆30%
Chiropractic Therapy (20 visits per Year, Preauthorization required after first 5 visits)	*50% (CHP)	◆*50%
Allergy/Serum	*\$15 per vial	◆30%
Allergy Injections (with office visit)	Covered 100% (after copay)	◆30%
<b>NEWBORN BENEFITS AT DELIVERY</b>	<b>YOU PAY</b>	
Medical/Surgical/Intensive Care/Newborn Complications (semi-private room)	10%	30%
Medical/Surgical/Intensive Care/Newborn Complications (Inpatient Ancillary)	10%	30%
Physician Visits (Inpatient)	10%	30%
Surgery (Inpatient)	10%	30%
Radiology/Pathology (Inpatient)	10%	30%
Anesthesiology (Inpatient)	10%	30%
<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 (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 Year)	*\$25	Not Covered

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Routine Hearing Exam (1 visit per Year)	*\$25	Not Covered
<b>TRANSPLANT BENEFIT (\$500,000 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%	◆30%
Medical Supplies (office)	Covered 100%	◆30%
Durable Medical Equipment	◆20%	◆30%
Orthotic Supplies (\$200 per Year)	◆20%	◆30%
Growth Hormone (\$8,000 per lifetime)	◆20%	◆30%
<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 Year - Separate from and not satisfied by the Medical or Prescription Drug Coinsurance Maximum). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	\$1,500 / \$3,000	\$1,500 / \$3,000
Mental Health Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical or Prescription Drug Deductible). Please note ■.	*\$600 / *\$1,800	*\$600 / *\$1,800
Inpatient Facility Semi-private Room	■ 10%	■ 30%
Inpatient Facility Ancillary	■ 10%	■ 30%
Inpatient Facility Physician Visits	■ 10%	■ 30%
Physician Office Visits Psychologist / Clinical Social Worker / APRN / Psychiatrist	*\$25	■ 30%
<b>OTHER LIMITED BENEFITS</b>	<b>YOU PAY</b>	
Adoption Indemnity Benefit	◆ 10%	
TMJ Syndrome diagnosis & non-surgical treatment (\$500 per lifetime)	◆*50%	◆*50%
Orthognathic/Mandibular Osteotomy (\$2,500 per lifetime)	◆*50%	◆*50%
Total Parenteral Nutrition (TPN) (\$10,000 per 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 / Year, \$5,000 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.

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Services designated ■ are subject to first dollar Mental Health Deductible.

Services designated ● are subject to first dollar Prescription Drug Deductible.

Services designated \* do not accumulate toward the applicable Coinsurance Maximum.

Services designated ◆ are subject to first dollar Medical Deductible