

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
GENERAL INFORMATION	YOU PAY	
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	
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	
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"> ●Generic - 20% (\$5 Min) ●Preferred Brand - 25% (\$10 Min) ●Non-Preferred Brand - 35% (\$20 Min) 	
Non-Participating Pharmacy (30 day supply) -- Member pays in full at time of purchase, then files for reimbursement	<ul style="list-style-type: none"> ●Generic - 20% (\$5 Min) ●Preferred Brand - 25% (\$10 Min) ●Non-Preferred Brand - 35% (\$20 Min) 	
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"> ●Generic - 20% (\$5 Min) ●Preferred Brand - 25% (\$10 Min) ●Non-Preferred Brand - 35% (\$20 Min) 	
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY	
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%
REHABILITATION THERAPY BENEFIT	YOU PAY	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	◆10%	◆30%
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)	\$100	
Orthodontic Injury Treatment (\$500 maximum per occurrence)	◆50%	
Dental Injury Treatment	◆20%	
PHYSICIAN & PROFESSIONAL SERVICES	YOU PAY	
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)	*\$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%
NEWBORN BENEFITS AT DELIVERY	YOU PAY	
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%
PREVENTIVE SERVICES	YOU PAY	
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
TRANSPLANT BENEFIT (\$500,000 lifetime combined maximum)	YOU PAY	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY	
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%
DENTAL BENEFITS	YOU PAY	
Impacted Teeth/Cysts/Tumors	Covered on Dental Plan	
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY	
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%
OTHER LIMITED BENEFITS	YOU PAY	
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