EMI HEALTH™

Administered by Educators Health Plans Life, Accident, and Health, Inc.
EMI Health Customer Service 801-270-2880 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.

Helpside **January 01, 2023 - December 31, 2023** **MedSave 7000**	**Care Plus**	
	Participating Provider Option	**Non-Participating Provider Option**
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Calendar Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year)	$7,000 / $14,000	None
Medical Deductible (Per Person/Family Per Year). Please note ♦	$7,000 / $14,000	$10,000 / $20,000
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 - Covered 100% ♦Preferred - Covered 100% ♦Non-Preferred - Covered 100%	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	♦Generic - Covered 100% ♦Preferred - Covered 100% ♦Non-Preferred - Covered 100%	
Specialty Pharmacy	Not Covered	
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
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
PHYSICIAN & PROFESSIONAL SERVICES	**YOU PAY**	
Physician Office Visits (primary care)	♦Covered 100%	♦50%
Physician Office Visits (secondary care)	♦Covered 100%	♦50%
Physician Office Visits (after hours)	♦Covered 100%	♦50%
Physician Visits (Inpatient)	♦Covered 100%	♦50%
Physician Visits (Outpatient)	♦Covered 100%	♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (office)	♦Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦Covered 100%	♦50%
Injections (office)	♦Covered 100%	♦50%
Surgery (office)	♦Covered 100%	♦50%
Surgery (Inpatient)	♦Covered 100%	♦50%
Surgery (Outpatient)	♦Covered 100%	♦50%
Anesthesiology (office)	♦Covered 100%	♦50%
Anesthesiology (Inpatient)	♦Covered 100%	♦50%
Anesthesiology (Outpatient)	♦Covered 100%	♦50%
Routine Prenatal & Delivery (Employee and Spouse maternity only)	♦Covered 100%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦Covered 100%	♦50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - limited to 20 visits per Year per injury/illness)	♦Covered 100%	♦50%
Chiropractic Therapy	Not Covered	Not Covered
Allergy Testing (excludes Blood Analysis)	♦Covered 100%	♦50%

Helpside January 01, 2023 - December 31, 2023 MedSave 7000	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	♦Covered 100%	♦50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦Covered 100%	♦50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦Covered 100%	♦50%
Skilled Nursing Facility (30 days per Year) (Admission must be within 3 days of discharge from Hospital Confinement)	♦Covered 100%	♦50%
Medical/Surgical Care (Outpatient)	♦Covered 100%	♦50%
Emergency Room (ER)	♦Covered 100%	♦Covered 100% for Emergency Services, all other services ♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦Covered 100%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦Covered 100%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦Covered 100%	♦50%
Newborn	♦Covered 100%	♦50%
InstaCare/Urgent Care Clinic	♦Covered 100%	♦50%
Eligible Preventive Services	Covered 100%	Not Covered
REHABILITATION THERAPY BENEFIT	**YOU PAY**	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	♦Covered 100%	♦50%
ACCIDENT AND LIFE THREATENING CONDITION	**YOU PAY**	
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)	♦Covered 100%	
Orthodontic Injury Treatment	♦Covered 100%	
Dental Injury Treatment	♦Covered 100%	
TRANSPLANT BENEFIT	**YOU PAY**	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Kidney, Artery or Vein	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	**YOU PAY**	
Diabetic Testing Supplies (90 day supply)	♦Covered 100%	♦50%
Medical Supplies	♦Covered 100%	♦50%
Medical Supplies (office)	♦Covered 100%	♦50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦Covered 100%	♦50%
Hearing Aids ($2,500 per Year)	♦Covered 100%	♦50%
Orthotic Supplies (foot inserts & arch supports)	Not Covered	Not Covered
Growth Hormone	Not Covered	Not Covered
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦Covered 100%	♦50%
Residential Treatment (30 days per Year)	♦Covered 100%	♦50%
Outpatient Services	♦Covered 100%	♦50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦Covered 100%	♦50%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	Not Covered	
TMJ Syndrome	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition Supplies	♦Covered 100%	Not Covered
Initial assessment and diagnosis of Primary Infertility	Not Covered	Not Covered
Reduction Mammoplasty	♦Covered 100%	Not Covered
Autism Applied Behavior Analysis	♦Covered 100%	♦50%

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.

PROVIDER NETWORK	
Utah	EMI Health Care Plus
National - Outside of Utah	Aetna National 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.