EMI HEALTH™

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

Washington County School District #832 August 01, 2022 - July 31, 2023 Option 1	Care Plus Participating Provider Option	Care Plus Non-Participating Provider Option
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note *	$5,000 / $10,000	$10,000 / $20,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Prescription Drug Deductible). 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 (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 Deductible (Per Person Per Year - Separate from and not satisfied by the Medical Deductible). Please note ●	$100	
Participating Pharmacy (30 day supply)	Generic - $10 ●Preferred - $25 ●Non-Preferred - $45	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	Generic - $10 ●Preferred - $50 ●Non-Preferred - $135	
Specialty Pharmacy (30 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	●$100	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	Must enroll to receive: *$0 Copay	
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 (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)	$30	♦40%
Physician Office Visits (secondary care)	$60	♦40%
Physician Office Visits (after hours)	$60	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Injections (office)	Covered 100%	♦40%
Surgery (office)	Covered 100%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Surgery (Ambulatory Surgical Center)	♦5%	♦40%
Anesthesiology (office)	Covered 100%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Anesthesiology (Ambulatory Surgical Center)	♦5%	♦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 - 60 visits per Year per injury/illness)	$60	♦40%
Neurodevelopmental Therapy (Outpatient physical, speech and occupational – Ages birth thru 6, limited to 40 visits per Year)	$60	♦40%
Chiropractic Therapy (15 visits per Year)	$60	♦40%
Allergy Testing	20%	♦40%

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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 (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦40%
Medical/Surgical Care (Outpatient)	♦20%	♦40%
Medical/Surgical Care (Ambulatory Surgical Center)	♦5%	♦40%
Emergency Room (ER)	$325	$325
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)	Covered 100%	♦40%
Minor Diagnostic Test, X-ray, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Newborn	20%	40%
InstaCare/Urgent Care Clinic	$60	♦40%
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)	♦20%	♦40%
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)	♦20%	
Orthodontic Injury Treatment	♦50%	
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)	$50	♦40%
Medical Supplies	♦20%	♦40%
Medical Supplies (office)	Covered 100%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦40%
Hearing Aids ($2,500 per Year)	♦20%	♦40%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦40%
Growth Hormone	♦20%	♦40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦40%
Residential Treatment (30 days per Year)	♦20%	♦40%
Outpatient Services	♦20%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	$30	♦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 (Limited to $2000 per person per lifetime)	♦20%	♦40%
Orthognathic/Mandibular Osteotomy	♦20%	♦40%
Total Parenteral Nutrition (TPN)	♦20%	♦40%
Initial assessment and diagnosis of Primary Infertility (Limited to $5000 per Year)	♦50%	Not Covered
Reduction Mammoplasty	♦20%	♦40%
Autism Applied Behavior Analysis	♦20%	♦40%
Nutritional Counseling (Limited to 3 visits per person per lifetime)	♦20%	♦40%

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

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
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.