



	EMPLOYEE	EMPLOYEE + 1	EMPLOYEE + 2	EMPLOYEE + 3 or more
MONTHLY RATES	\$104.00	\$208.00	\$312.00	\$416.00
UEA Member Pays*	\$27.00	\$131.00	\$235.00	\$339.00

EFFECTIVE DATE: July 1, 2011 - June 30, 2012

Administered by Educators Mutual Insurance Association
 EMI Health Customer Service 801-270-2880 or 1-800-662-5852
 Self Funded Employee Medical Benefit Plan

PLEASE NOTE: All services are subject to the EMI Health Table of Allowances. This is a Limited Benefit Plan.

Utah Education Association Effective beginning July 1, 2011 BasicMed 10K	Care Participating Provider Option
GENERAL INFORMATION	YOU PAY
Annual Maximum Benefit	\$10,000 per person
Preexisting Condition Window Period (Age 19 and above)	6 months prior
Preexisting Condition Waiting Period (Age 19 and above)	First 8 months of coverage / 18 months Late Enrollees
Dependent Age Limit	26
Coinsurance Maximum (Per Person/Family Per 90 Day Period)	\$2,500 / \$5,000
First Dollar Deductible (Per Person/Family Per 90 Day Period)	*\$500 / *\$1,000
Non-Preauthorization Provider Sanction	50% Reduction in Payment
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)	EMIA Pays up to \$5 per prescription (After Discount)
Mail Order (90 day supply)	EMIA Pays up to \$5 per prescription (After Discount)
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦25%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦25%
Skilled Nursing Facility (15 days per 90 Day Period) (Admission must be within 5 days of discharge from Hospital Confinement)	♦25%
Medical/Surgical Care (Outpatient)	♦25%
Emergency Room (ER) - Participating	♦25%
Emergency Room (ER) - Non-Participating	♦25% + amounts exceeding the Table of Allowances
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient) (Limited to 1 of each type of test per person per 90 day period)	♦25%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦25%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦25%
Newborn	♦25%
InstaCare Clinic (see Combined Visit Limit under Physician and Professional Services)	\$35
Eligible Preventive Services	Covered 100%
REHABILITATION THERAPY BENEFIT	YOU PAY
Inpatient – physical, speech, occupational, cardiac, or pulmonary (5 days per person per 90 Day Period)	♦25%
ACCIDENT AND LIFE THREATENING CONDITION	YOU PAY
Medical/Surgical – Physician/Facility/ER	Covered as any other condition
Ambulance Land/Air (Accident & Life-threatening)	♦25%
PHYSICIAN & PROFESSIONAL SERVICES	YOU PAY
Physician Office Visits (primary care)	\$25
Physician Office Visits (secondary care)	\$35
Physician Office Visits (after hours)	\$35
Combined Office Visit and InstaCare Limit	3 Visits per person per 90 Day Period
Physician Visits (Inpatient)	♦25%
Physician Visits (Outpatient)	♦25%
Major Diagnostic Test, CT Scan, MRI, NMR (office) (Limited to 1 of each type of test per 90 day period)	♦25%
Minor Diagnostic Test, X-ray, Lab (office)	Covered 100%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦25%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦25%
Radiology/Pathology (office)	Covered 100%
Radiology/Pathology (Inpatient)	♦25%
Radiology/Pathology (Outpatient)	♦25%
Injections (office)	Covered 100%

PLEASE NOTE: All services are subject to EMI Health Table of Allowances. This is a Limited Benefit Plan.

Utah Education Association Effective beginning July 1, 2011 BasicMed 10K	Care Participating Provider Option
Surgery (Inpatient)	◆25%
Surgery (Outpatient)	◆25%
Anesthesiology (office)	Covered 100%
Anesthesiology (Inpatient)	◆25%
Anesthesiology (Outpatient)	◆25%
Routine Prenatal & Delivery (Dependent maternity included)	◆25%
Home Health Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	◆25%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 4 visits per 90 Day Period)	\$35
Chiropractic Therapy	Not Covered
Allergy Testing	◆25%
Allergy Treatment/Serum	◆25%
PREVENTIVE SERVICES	YOU PAY
Routine Physical Exam (1 visit per 90 Day Period)	Covered 100%
Routine Gynecological Exam (1 visit per 90 Day Period)	Covered 100%
Routine Pap Smear & Mammogram (1 per 90 Day Period)	Covered 100%
Routine Well-Baby Exams	Covered 100%
Covered Immunizations	Covered 100%
Routine Vision Exam (1 visit per 90 Day Period)	Covered 100%
Routine Hearing Exam (1 visit per 90 Day Period)	Covered 100%
TRANSPLANT BENEFIT	YOU PAY
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY
Medical Supplies	◆25%
Medical Supplies (office)	Covered 100%
Durable Medical Equipment	◆25%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY
Inpatient Facility Semi-private Room	Not Covered
Inpatient Facility Ancillary	Not Covered
Inpatient Facility Physician Visits	Not Covered
Physician Office Visits Psychologist / Clinical Social Worker / APRN / Psychiatrist	Not Covered
OTHER LIMITED BENEFITS	YOU PAY
Adoption Indemnity Benefit	Not Covered
TMJ Syndrome	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered
Total Parenteral Nutrition (TPN)	Not Covered
Primary Infertility	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 the EMI Health Customer Service Department.

Services designated * do not accumulate toward your Coinsurance Maximum.

Services designated ◆ are subject to first dollar Deductible.

NOTICE

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by Utah Education Association and its affiliates, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of \$10,000 on all covered benefits. In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services, based on your health plan's representation, that providing \$750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact EMI Health at 800-662-5851.