

## Educators Health Care

Administered by Educators Mutual Insurance Association  
 Educators Customer Service 801-262-7475 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.		
Southern Utah University #144 351 W. University Blvd., Cedar City, UT 84720 July 01, 2009 - June 30, 2010	Educators Care Plus	
	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 8 months of coverage / 18 months Late Enrollees	
Benefit Accumulator	Plan Year	
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.	\$1,000 / \$2,000	\$1,000 / \$2,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Mental Health or Prescription Drug Deductible). Please note ♦.	*\$150 / *\$300	*\$150 / *\$300
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.	*\$3,500 / *\$10,500	
Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical or Mental Health Deductible). Please note ♦.	None	
Participating Pharmacy (30 day supply)	Generic - \$5 Preferred Brand - \$30 Non-Preferred Brand - 50%	
Non-Participating Pharmacy (30 day supply)	Not Covered	
Mail Order (90 day supply)	Generic - \$15 Preferred Brand - \$90 Non-Preferred Brand - 50%	
<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)	♦20%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦40%
Skilled Nursing Facility (60 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦40%
Medical/Surgical Care (Outpatient)	♦20%	♦40%
Emergency Room (ER)	\$100	♦\$100 then 20%
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)	♦20%	♦40%
Newborn	20%	40%
InstaCare/Urgent Care Clinic	\$30	♦\$30 then 20%
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (30 days per person per Year)	♦20%	♦40%
<b>ACCIDENT AND LIFE THREATENING CONDITION</b>	<b>YOU PAY</b>	
Supplemental Accident/Life-Threatening Illness Benefit	Covered 100% for first \$1000 per Year then regular benefits apply	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	
Ambulance Land/Air (Accident & Life-threatening)	♦20%	Covered as a Participating Benefit subject to the Table of Allowance
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)	\$20	♦\$20 then 20%
Physician Office Visits (secondary care)	\$30	♦\$30 then 20%
Physician Office Visits (after hours)	\$30	♦\$30 then 20%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (office)	Covered 100%	Covered as a Participating Benefit subject to the Table of Allowance

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	Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆20%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	◆20%	◆40%
Radiology/Pathology (office)	Covered 100%	◆40%
Radiology/Pathology (Inpatient)	◆20%	◆40%
Radiology/Pathology (Outpatient)	◆20%	◆40%
Injections (office)	Covered 100%	◆40%
Surgery (office)	Covered 100%	◆40%
Surgery (Inpatient)	◆20%	◆40%
Surgery (Outpatient)	◆20%	◆40%
Anesthesiology (office)	Covered 100%	◆40%
Anesthesiology (Inpatient)	◆20%	◆40%
Anesthesiology (Outpatient)	◆20%	◆40%
Routine Prenatal & Delivery (Dependent maternity included)	◆20%	◆40%
Home Health Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	◆20%	◆20%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 30 visits per Year)	\$20	◆\$20 then 20%
Chiropractic Therapy (10 visits per Year)	\$20 (CHP)	◆\$20 then 20%
Allergy Testing	◆20%	◆40%
Allergy Treatment/Serum	◆20%	◆40%
<b>PREVENTIVE SERVICES</b>	<b>YOU PAY</b>	
Routine Physical Exam (1 visit per Year)	\$20	◆\$20 then 20%
Routine Gynecological Exam (1 visit per Year)	\$20	◆\$20 then 20%
Family History Exam (1 visit per Year)	\$20	◆\$20 then 20%
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	◆20%
Routine Well-Baby Exams	\$20	◆\$20 then 20%
Covered Immunizations	Covered 100%	◆20%
Routine Vision Exam (1 visit per Year)	\$20	◆\$20 then 20%
Routine Hearing Exam (1 visit per Year)	\$20	◆\$20 then 20%
<b>TRANSPLANT BENEFIT</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%	◆40%
Medical Supplies (office)	Covered 100%	◆40%
Durable Medical Equipment (\$5,000 per Year)	◆20%	◆20%
Orthotic Supplies (\$200 per Year)	◆20%	◆20%
Growth Hormone (\$8,000 per lifetime)	◆20%	◆40%
<b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>	<b>YOU PAY</b>	
<b>EAP Services provided through Blomquist Hale at 801-262-9619</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.	\$1,000 / \$2,000	\$1,000 / \$2,000
Mental Health Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical or Prescription Drug Deductible). Please note ■.	*\$150 / *\$300	*\$150 / *\$300
Inpatient Facility Semi-private Room	■ 50%	■ 50%
Inpatient Facility Ancillary	■ 50%	■ 50%
Inpatient Facility Physician Visits	■ 50%	■ 50%
Physician Office Visits Psychologist / Clinical Social Worker / APRN / Psychiatrist	■ 50%	■ 50%
<b>OTHER LIMITED BENEFITS</b>	<b>YOU PAY</b>	
Adoption Indemnity Benefit	The Plan pays a maximum of \$4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment (\$500 per lifetime)	◆*50%	Not Covered
Orthognathic/Mandibular Osteotomy (\$2,500 per lifetime)	◆*50%	Not Covered
Total Parenteral Nutrition (TPN) (\$10,000 per Year)	◆*50%	Not Covered
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