

Utah Valley University

Educators Customer Service 262-7475 or 1-800-662-5851

Self-funded Employee Medical Benefit Plan - Administered by Educators Mutual Insurance Association of Utah

All services are subject to the Table of Allowances. The Covered Person is responsible for all fees in excess of the Table of Allowances when using a Provider that does not participate on the Care Plus or Beech Street panels. Non-participating Provider benefits apply to Beech Street Providers outside of Utah; however, the Covered Person is not responsible for fees in excess of the Table of Allowances.

Utah Valley University #128 800 West University Parkway, Orem, Utah 84058-5999 801-863-8389	Educators Care Plus	
Summary of Benefits July 1, 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 8 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 Prescription Drug Coinsurance Maximum). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	\$1,500 / \$3,000	\$2,500 / \$5,000
Medical Deductible (Per Person/Family Per Year). Please note ♦.	None	*\$300 / *\$900
Non-Preauthorization Patient Penalty	Not Applicable	50% reduction in benefits, limited to \$2,000 penalty per incident
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
Non-Precertification EAP Penalty	Not Applicable	
PRESCRIPTION DRUG BENEFITS	YOU PAY	
Prescription Drug Coinsurance Maximum (Per Person/Family Per Year - Separate from and not satisfied by the Medical Coinsurance Maximum). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	\$1,100 / \$2,200	
Participating Pharmacy (30 day supply)	Generic - \$4 Preferred Brand - 30% Non-Preferred Brand - 50%	
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)	Generic - \$8 Preferred Brand - 30% Non-Preferred Brand - 50%	
DENTAL BENEFITS	YOU PAY	
Impacted Teeth/Cysts/Tumors	Covered 100%	♦ 30%
HOSPITAL/FACILITY BENEFITS (Physician and Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	*\$100 then 10%	♦ 30%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	10%	♦ 30%
Skilled Nursing Facility (60 day per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	10%	♦ 30%
Medical/Surgical Care (Outpatient)	10%	♦ 30%
Emergency Room (ER)	*\$150	♦ 30%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	10%	♦ 30%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	10%	♦ 30%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	10%	♦ 30%
Newborn	10%	♦ 30%
InstaCare Clinic	*\$30	♦ 30%
REHABILITATION THERAPY BENEFIT	YOU PAY	
Inpatient – physical, speech, occupational, cardiac, or pulmonary	Covered 100%	♦ 30%

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ACCIDENT AND LIFE THREATENING ILLNESS	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)	20%	
Orthodontic Injury Treatment	Covered 100%	
Dental Injury Treatment	20%	
PHYSICIAN & PROFESSIONAL SERVICES	YOU PAY	
Physician Office Visits (primary care)	*\$20	◆ 30%
Physician Office Visits (secondary care)	*\$20	◆ 30%
Physician Office Visits (after hours)	*\$30	◆ 30%
Physician Visits (Inpatient)	10%	◆ 30%
Physician Visits (Outpatient)	10%	◆ 30%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	10%	◆ 30%
Minor Diagnostic Test, X-ray, Lab (office)	Covered 100%	◆ 30%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	10%	◆ 30%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	10%	◆ 30%
Radiology/Pathology (office)	Covered 100%	◆ 30%
Radiology/Pathology (Inpatient)	10%	◆ 30%
Radiology/Pathology (Outpatient)	10%	◆ 30%
Injections (office)	Covered 100%	◆ 30%
Surgery (office)	Covered 100%	◆ 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)	*\$20 first visit only then Covered 100%	◆ 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 - \$5,000 per Year)	*\$20	◆ 30%
Chiropractic Therapy (20 visits per person per Year)	*\$20 (CHP)	◆ *50%
Allergy Testing	Covered 100%	◆ 30%
Allergy Treatment/Serum	*\$80 per Year	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
Family History Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (1 visit per Year)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Immunizations (excludes immunizations required exclusively for foreign travel)	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Year)	*\$20	Not Covered
Routine Hearing Exam (1 visit per Year)	*\$20	Not Covered
TRANSPLANT BENEFIT	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	20%	Not Covered
Growth Hormone	20%	◆ 30%

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MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY	
Inpatient Facility Semi-private Room (21 days per Year)	*20%	◆ *50%
Inpatient Facility Ancillary (21 days per Year)	*20%	◆ *50%
Inpatient Facility Physician Visits (21 visits per Year, 1 visit per day)	*20%	◆ *50%
Physician Office Visits (20 visits per Year, 1 visit per day)		
Psychologist / Clinical Social Worker / APRN	*\$25	◆ *50%
Psychiatrist	*\$50	◆ *50%
OTHER LIMITED BENEFITS	YOU PAY	
Adoption Indemnity Benefit	The Plan pays a maximum \$4,000 towards adoption expenses per child	
TMJ Syndrome diagnosis & non-surgical treatment (\$500 per lifetime)	*50%	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN) (\$100,000 per lifetime)	10%	◆ *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 per Year, \$5,000 per 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.

Services designated * do not accumulate toward the applicable Coinsurance Maximum.

Services designated ◆ are subject to first dollar Medical Deductible