EMI HEALTH™

Administered by Educators Health Plans Life, Accident, and Health, Inc.
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.

Teachers Health Trust **January 01, 2025 - December 31, 2025**	**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). Please note *	$7,500 / $15,000	$7,500 / $15,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	$500 / $1,500	$1,500 / $4,500
Non-Preauthorization Patient Penalty	Not Applicable	No Coverage
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 (up to 30 day supply)	Generic - $15 Preferred - 25% ($100 Max) Non-Preferred - 40%	
Non-Participating Pharmacy	Not Covered	
Mail Order (up to 90 day supply)	Generic - $40 Preferred - 25% ($300 Max) Non-Preferred - 40%	
Specialty Pharmacy (up to 90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	25% ($1,500 Max)	
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**	
Convenience Clinic	$40	♦50%
Physician Office Visits (primary care)	$15	♦50%
Physician Office Visits (secondary care)	$30	♦50%
Physician Office Visits (after hours)	$30	♦50%
Physician Visits (Inpatient)	♦20%	♦50%
Physician Visits (Outpatient)	♦20%	♦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)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦Covered 100%	♦50%
Injections (office)	20%	♦50%
Surgery (office)	20%	♦50%
Surgery (Inpatient)	20%	♦50%
Surgery (Outpatient)	20%	♦50%
Anesthesiology (office)	20%	♦50%
Anesthesiology (Inpatient)	20%	♦50%
Anesthesiology (Outpatient)	20%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	$10 office visit; 20% all other services	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦50%
Rehabilitation Therapy (Outpatient physical, speech or occupational - 20 visits per Year per injury/illness; Pre-Authorization required after 20 visits)	$30	♦50%
Rehabilitation Therapy (Outpatient cardiac or pulmonary)	$30	♦50%
Chiropractic Therapy (20 visits per Year)	$30	♦50%
Acupuncture Services (20 visits per Year)	$30	♦50%

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Allergy Testing	♦20%	♦50%
Allergy Treatment/Serum	♦20%	♦50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦50%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦50%
Medical/Surgical Care (Outpatient)	♦20%	♦50%
Emergency Room (ER)	♦$300	♦$300
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦Covered 100%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦Covered 100%	♦50%
Newborn	Covered 100%	♦50%
Urgent Care Clinic	$30	♦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)	♦20%	♦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)	♦20%	
Orthodontic Injury Treatment	*50%	
Dental Injury Treatment	♦20%	
TRANSPLANT BENEFIT	**YOU PAY**	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	$1500 then Covered 100%	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	**YOU PAY**	
Diabetic Testing Supplies (90 day supply)	Covered 100%	Covered 100%
Medical Supplies	♦20%	♦50%
Medical Supplies (office)	♦20%	♦50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦50%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦50%
Growth Hormone	♦20%	♦50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦50%
Residential Treatment (30 days per Year)	♦20%	♦50%
Partial Hospitalization and Intensive Outpatient Services	♦20%	♦50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	$30	♦50%
ADDITIONAL BENEFITS	**YOU PAY**	
Hearing Aids, including repair and replacement (per ear every three years)	Covered 100% up to $2500 (3 years)	$500 then Covered 100% up to $2500 (3 years)
Wig or hairpiece (following chemotherapy or radiation course of treatment)	♦20% up to $1000 per condition	♦20% up to $1000 per condition
TMJ Syndrome diagnosis & non-surgical treatment	♦20%	♦50%
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN)	♦20%	♦50%
Initial assessment and diagnosis of Primary Infertility	♦20%	♦50%
Reduction Mammoplasty	♦20%	♦50%
Autism Applied Behavior Analysis	♦20%	♦50%

Services designated ♦ are subject to the 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.