

# UEA New Hire BasicMED

Administered by Educators Mutual Insurance Association

	EMPLOYEE	EMPLOYEE + 1	EMPLOYEE + 2	EMPLOYEE + 3 or more
MONTHLY RATES	\$105.00	\$210.00	\$315.00	\$420.00
UEA Member Pays*	\$21.00	\$126.00	\$231.00	\$336.00

EFFECTIVE DATE: July 1, 2009 - June 30, 2010

UEA New Hire BasicMed Effective beginning July 1, 2009 Short Term Medical Plan	Educators Care Plus	
	Participating Provider Option	Non-Participating Provider Option
<b>GENERAL INFORMATION</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
90 Day Period Maximum Benefit	\$10,000 per person	
Preexisting Condition Window Period	6 months prior	
Preexisting Condition Waiting Period	First 8 months of coverage / 18 months Late Enrollees	
Dependent Age Limit	26	
Coinsurance Maximum (Per Person/Family Per 90 Day Period - Separate from and not satisfied by the Mental Health Coinsurance Maximum)	\$2,500 / \$5,000	\$5,000 / \$10,000
First Dollar Deductible (Per Person/Family Per 90 Day Period - Separate from and not satisfied by the Mental Health Deductible)	*\$500 / *\$1,000	*\$1,000 / *\$2,000
Non-Preauthorization Patient Penalty	50% Reduction in Payment	50% Reduction in Payment
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
Non-Precertification EAP Penalty	Not Applicable	Not Applicable
<b>PRESCRIPTION DRUG BENEFITS</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
Participating Pharmacy (30 day supply)	EMIA Pays up to \$5 per prescription (After Discount)	
Mail Order (30 day supply)	EMIA Pays up to \$5 per prescription (After Discount)	
<b>HOSPITAL/FACILITY BENEFITS</b> (Physician & Professional Services are not included in this section.)	<b>YOU PAY</b>	<b>YOU PAY</b>
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦25%	♦50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦25%	♦50%
Skilled Nursing Facility (15 days per 90 Day Period) (Admission must be within 5 days of discharge from Hospital Confinement)	♦25%	♦50%
Medical/Surgical Care (Outpatient)	♦25%	♦50%
Emergency Room (ER)	♦25%	♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient) (Limited to 1 of each type of test per person per 90 day period)	♦25%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦25%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient including ER)	♦25%	♦50%
Newborn	♦25%	♦50%
InstaCare Clinic (see Combined Visit Limit under Physician and Professional Services)	\$30	♦50%
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
Inpatient – physical, speech, occupational, cardiac, or pulmonary (5 days per person per 90 Day Period)	♦25%	♦50%
<b>ACCIDENT AND LIFE THREATENING CONDITION</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
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)	♦25%	
<b>PHYSICIAN &amp; PROFESSIONAL SERVICES</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
Physician Office Visits (primary care)	\$20	♦50%
Physician Office Visits (secondary care)	\$30	♦50%
Physician Office Visits (after hours)	\$30	♦50%
Combined Office Visit and InstaCare Limit	3 Visits per person per 90 Day Period	
Physician Visits (Inpatient)	♦25%	♦50%
Physician Visits (Outpatient including ER)	♦25%	♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (office) (Limited to 1 of each type of test per person per 90 day period)	♦25%	♦50%
Minor Diagnostic Test, X-ray, Lab (office)	Covered 100%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦25%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient including ER)	♦25%	♦50%
Radiology/Pathology (office)	Covered 100%	♦50%
Radiology/Pathology (Inpatient)	♦25%	♦50%
Radiology/Pathology (Outpatient including ER)	♦25%	♦50%
Injections (office)	Covered 100%	♦50%
Surgery (office)	Covered 100%	♦50%
Surgery (Inpatient)	♦25%	♦50%
Surgery (Outpatient including ER)	♦25%	♦50%

Services designated \* do not accumulate toward your Coinsurance Maximum.

Services designated ♦ are subject to first dollar Deductible.

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

Anesthesiology (office)	Covered 100%	◆50%
Anesthesiology (Inpatient)	◆25%	◆50%
Anesthesiology (Outpatient including ER)	◆25%	◆50%
Routine Prenatal & Delivery (Dependent maternity included)	◆25%	◆50%
Home Health Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	◆25%	◆50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 4 visits per 90 Day Period)	\$30	◆50%
Chiropractic Therapy	Not Covered	Not Covered
Allergy Testing	◆25%	◆50%
Allergy Treatment/Serum	◆25%	◆50%
<b>PREVENTIVE SERVICES</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
Routine Physical Exam (1 visit per 90 Day Period)	\$20	Not Covered
Routine Gynecological Exam (1 visit per 90 Day Period)	\$20	Not Covered
Routine Pap Smear & Mammogram (1 per 90 Day Period)	Covered 100%	Not Covered
Routine Well-Baby Exams	\$20	Not Covered
Covered Child Immunizations (to 2nd birthday)	Covered 100%	Not Covered
Routine Vision Exam (1 visit per 90 Day Period)	\$20	Not Covered
Routine Hearing Exam (1 visit per 90 Day Period)	\$20	Not Covered
<b>TRANSPLANT BENEFIT</b>	<b>YOU PAY</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>	<b>YOU PAY</b>
Medical Supplies	◆25%	◆50%
Medical Supplies (office)	◆Covered 100%	◆50%
Durable Medical Equipment (Rental only)	◆25%	◆50%
<b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
Coinsurance Maximum (Per Person/Family Per 90 Day Period - Separate from and not satisfied by the Medical Coinsurance Maximum)	\$2,500 / \$5,000	\$5,000 / \$10,000
First Dollar Deductible (Per Person/Family Per 90 Day Period - Separate from and not satisfied by the Medical Deductible)	*\$500 / *\$1,000	*\$1,000 / *\$2,000
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	◆\$30	◆50%
<b>OTHER LIMITED BENEFITS</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
Adoption Indemnity Benefit	Not Covered	Not Covered
TMJ Syndrome	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN)	Not Covered	Not Covered
Primary Infertility	Not Covered	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 your Coinsurance Maximum.

Services designated ◆ are subject to first dollar Deductible.