

# UEA New Hire BasicMED

Administered by Educators Mutual Insurance Association

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Administration..... 801-262-7476 or 1-800-662-5850

Customer Service..... 801-270-2880 or 1-800-662-5852

	EMPLOYEE	EMPLOYEE +1	EMPLOYEE +2	EMPLOYEE +3 or more
<b>MONTHLY RATES</b>	\$102.00	\$204.00	\$306.00	\$408.00
<b>UEA Member Pays*</b>	\$25.00	\$127.00	\$229.00	\$331.00

EFFECTIVE DATE: July 1, 2010 - June 30, 2011

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

UEA New Hire BasicMed Effective beginning July 1, 2010 Short-Term Medical Plan	Educators Care Participating Provider Option
<b>GENERAL INFORMATION</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)	\$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
<b>PRESCRIPTION DRUG BENEFITS</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>
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)	♦25%
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 including ER)	♦25%
Newborn	♦25%
InstaCare Clinic (see Combined Visit Limit under Physician and Professional Services)	\$35
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>
Inpatient – physical, speech, occupational, cardiac, or pulmonary (5 days per person per 90 Day Period)	♦25%
<b>ACCIDENT AND LIFE THREATENING CONDITION</b>	<b>YOU PAY</b>
Medical/Surgical – Physician/Facility/ER	Covered as any other condition
Ambulance Land/Air (Accident & Life-threatening)	♦25%
<b>PHYSICIAN &amp; PROFESSIONAL SERVICES</b>	<b>YOU PAY</b>
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 including ER)	♦25%
Major Diagnostic Test, CT Scan, MRI, NMR (office) (Limited to 1 of each type of test per person 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 including ER)	♦25%
Radiology/Pathology (office)	Covered 100%
Radiology/Pathology (Inpatient)	♦25%
Radiology/Pathology (Outpatient including ER)	♦25%
Injections (office)	Covered 100%
Surgery (office)	Covered 100%
Surgery (Inpatient)	♦25%
Surgery (Outpatient including ER)	♦25%
Anesthesiology (office)	Covered 100%

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

Services designated ♦ are subject to first dollar Deductible.

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Anesthesiology (Inpatient)	◆25%
Anesthesiology (Outpatient including ER)	◆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%
<b>PREVENTIVE SERVICES</b>	<b>YOU PAY</b>
Routine Physical Exam (1 visit per 90 Day Period)	\$25
Routine Gynecological Exam (1 visit per 90 Day Period)	\$25
Routine Pap Smear & Mammogram (1 per 90 Day Period)	Covered 100%
Routine Well-Baby Exams	\$25
Covered Child Immunizations (to 2nd birthday)	Covered 100%
Routine Vision Exam (1 visit per 90 Day Period)	\$25
Routine Hearing Exam (1 visit per 90 Day Period)	\$25
<b>TRANSPLANT BENEFIT</b>	<b>YOU PAY</b>
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition
<b>MEDICAL SUPPLIES &amp; EQUIPMENT</b>	<b>YOU PAY</b>
Medical Supplies	◆25%
Medical Supplies (office)	◆Covered 100%
Durable Medical Equipment (Rental only)	◆25%
<b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>	<b>YOU PAY</b>
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
<b>OTHER LIMITED BENEFITS</b>	<b>YOU PAY</b>
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 Educators Customer Service Department.