



Educational Services, Inc.

2023 EMI Health Member Benefits Guide



Administered by EMI Health
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.		
Educational Services, Inc. 2023 Contract Year A 5000 5000 QHDHP 100%	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)	\$5,000 / \$10,000	\$15,000 / \$30,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	\$5,000 / \$10,000	\$10,000 / \$20,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	\$500 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 (30 day supply)	♦Generic - Covered 100% ♦Preferred - Covered 100% ♦Non-Preferred - Covered 100%	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	♦Generic - Covered 100% ♦Preferred - Covered 100% ♦Non-Preferred - Covered 100%	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy. Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	♦Covered 100% 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	
Physician Office Visits (primary care)	♦Covered 100%	♦50%
Physician Office Visits (secondary care)	♦Covered 100%	♦50%
Physician Office Visits (after hours)	♦Covered 100%	♦50%
Physician Visits (Inpatient)	♦Covered 100%	♦50%
Physician Visits (Outpatient)	♦Covered 100%	♦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)	♦Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦Covered 100%	♦50%
Injections (office)	♦Covered 100%	♦50%
Surgery (office)	♦Covered 100%	♦50%
Surgery (Inpatient)	♦Covered 100%	♦50%
Surgery (Outpatient)	♦Covered 100%	♦50%
Anesthesiology (office)	♦Covered 100%	♦50%
Anesthesiology (Inpatient)	♦Covered 100%	♦50%
Anesthesiology (Outpatient)	♦Covered 100%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	♦Covered 100%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦Covered 100%	♦50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness)	♦Covered 100%	♦50%
Chiropractic Therapy (20 visits per Year)	♦Covered 100%	♦50%
Allergy Testing	♦Covered 100%	♦50%

Educational Services, Inc. 2023 Contract Year A 5000 5000 QHDP 100%	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	◆Covered 100%	◆50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆Covered 100%	◆50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆Covered 100%	◆50%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	◆Covered 100%	◆50%
Medical/Surgical Care (Outpatient)	◆Covered 100%	◆50%
Emergency Room (ER)	◆Covered 100%	◆Covered 100%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	◆Covered 100%	◆50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆Covered 100%	◆50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	◆Covered 100%	◆50%
Newborn	◆Covered 100%	◆50%
Urgent Care Clinic	◆Covered 100%	◆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)	◆Covered 100%	◆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)	◆Covered 100%	
Orthodontic Injury Treatment	◆Covered 100%	
Dental Injury Treatment	◆Covered 100%	
TRANSPLANT BENEFIT	YOU PAY	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY	
Diabetic Testing Supplies (90 day supply)	◆Covered 100%	◆50%
Medical Supplies	◆Covered 100%	◆50%
Medical Supplies (office)	◆Covered 100%	◆50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	◆Covered 100%	◆50%
Hearing Aids (\$2,500 per Year)	◆Covered 100%	◆50%
Orthotic Supplies (foot inserts & arch supports)	◆Covered 100%	◆50%
Growth Hormone	◆Covered 100%	◆50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY	
Inpatient Services (non-residential)	◆Covered 100%	◆50%
Residential Treatment (30 days per Year)	◆Covered 100%	◆50%
Outpatient Services	◆Covered 100%	◆50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	◆Covered 100%	◆50%
ADDITIONAL BENEFITS	YOU PAY	
TMJ Syndrome diagnosis & non-surgical treatment	◆Covered 100%	Not Covered
Orthognathic/Mandibular Osteotomy	◆Covered 100%	Not Covered
Total Parenteral Nutrition (TPN)	◆Covered 100%	Not Covered
Initial assessment and diagnosis of Primary Infertility	◆Covered 100%	Not Covered
Reduction Mammoplasty	◆Covered 100%	Not Covered
Autism Applied Behavior Analysis	◆Covered 100%	◆50%

Services designated ◆ are subject to first dollar 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
Arizona	Blue Cross® Blue Shield® of Arizona
Outside of Utah and Arizona	First Health

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

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	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 *	\$6,500 / \$13,000	\$13,000 / \$26,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	\$5,000 / \$10,000	\$10,000 / \$20,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	\$500 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 (30 day supply)	Generic - \$15 Preferred - \$40 Non-Preferred - \$80	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	Generic - \$38 Preferred - \$100 Non-Preferred - \$200	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	25% (\$250 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	
Physician Office Visits (primary care)	\$30	♦50%
Physician Office Visits (secondary care)	\$60	♦50%
Physician Office Visits (after hours)	\$60	♦50%
Physician Visits (Inpatient)	♦Covered 100%	♦50%
Physician Visits (Outpatient)	♦Covered 100%	♦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)	♦Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	Covered 100%	♦50%
Injections (office)	Covered 100%	♦50%
Surgery (office)	Covered 100%	♦50%
Surgery (Inpatient)	♦Covered 100%	♦50%
Surgery (Outpatient)	♦Covered 100%	♦50%
Anesthesiology (office)	Covered 100%	♦50%
Anesthesiology (Inpatient)	♦Covered 100%	♦50%
Anesthesiology (Outpatient)	♦Covered 100%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	♦Covered 100%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦Covered 100%	♦50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness)	\$30	♦50%
Chiropractic Therapy (20 visits per Year)	\$30	♦50%
Allergy Testing	Covered 100%	♦50%

Educational Services, Inc. 2023 Contract Year A 5000 6500 100%	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	Covered 100%	♦50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦Covered 100%	♦50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦Covered 100%	♦50%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦Covered 100%	♦50%
Medical/Surgical Care (Outpatient)	♦Covered 100%	♦50%
Emergency Room (ER)	\$350	\$350
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦Covered 100%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦Covered 100%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	Covered 100%	♦50%
Newborn	Covered 100%	50%
Urgent Care Clinic	\$75	♦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)	♦Covered 100%	♦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	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY	
Diabetic Testing Supplies (90 day supply)	\$100	♦50%
Medical Supplies	♦Covered 100%	♦50%
Medical Supplies (office)	Covered 100%	♦50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦Covered 100%	♦50%
Hearing Aids (\$2,500 per Year)	♦Covered 100%	♦50%
Orthotic Supplies (foot inserts & arch supports)	♦Covered 100%	♦50%
Growth Hormone	♦Covered 100%	♦50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY	
Inpatient Services (non-residential)	♦Covered 100%	♦50%
Residential Treatment (30 days per Year)	♦Covered 100%	♦50%
Outpatient Services	♦Covered 100%	♦50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	\$30	♦50%
ADDITIONAL BENEFITS	YOU PAY	
TMJ Syndrome diagnosis & non-surgical treatment	♦*50%	Not Covered
Orthognathic/Mandibular Osteotomy	♦*50%	Not Covered
Total Parenteral Nutrition (TPN)	♦*50%	Not Covered
Initial assessment and diagnosis of Primary Infertility	♦*50%	Not Covered
Reduction Mammoplasty	♦*50%	Not Covered
Autism Applied Behavior Analysis	♦Covered 100%	♦50%

Services designated ♦ are subject to first dollar 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
Arizona	Blue Cross® Blue Shield® of Arizona
Outside of Utah and Arizona	First Health

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

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Educational Services, Inc. 2023 Contract Year A 3000 3000 QHDHP 100%	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)	\$3,000 / \$6,000	\$10,000 / \$20,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	\$3,000 / \$6,000	\$6,000 / \$12,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	\$500 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 (30 day supply)	♦Generic - Covered 100% ♦Preferred - Covered 100% ♦Non-Preferred - Covered 100%	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	♦Generic - Covered 100% ♦Preferred - Covered 100% ♦Non-Preferred - Covered 100%	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy. Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	♦Covered 100%	
	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	
Physician Office Visits (primary care)	♦Covered 100%	♦50%
Physician Office Visits (secondary care)	♦Covered 100%	♦50%
Physician Office Visits (after hours)	♦Covered 100%	♦50%
Physician Visits (Inpatient)	♦Covered 100%	♦50%
Physician Visits (Outpatient)	♦Covered 100%	♦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)	♦Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦Covered 100%	♦50%
Injections (office)	♦Covered 100%	♦50%
Surgery (office)	♦Covered 100%	♦50%
Surgery (Inpatient)	♦Covered 100%	♦50%
Surgery (Outpatient)	♦Covered 100%	♦50%
Anesthesiology (office)	♦Covered 100%	♦50%
Anesthesiology (Inpatient)	♦Covered 100%	♦50%
Anesthesiology (Outpatient)	♦Covered 100%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	♦Covered 100%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦Covered 100%	♦50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness)	♦Covered 100%	♦50%
Chiropractic Therapy (20 visits per Year)	♦Covered 100%	♦50%
Allergy Testing	♦Covered 100%	♦50%

Educational Services, Inc. 2023 Contract Year A 3000 3000 QHDP 100%	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	◆Covered 100%	◆50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆Covered 100%	◆50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆Covered 100%	◆50%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	◆Covered 100%	◆50%
Medical/Surgical Care (Outpatient)	◆Covered 100%	◆50%
Emergency Room (ER)	◆Covered 100%	◆Covered 100%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	◆Covered 100%	◆50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆Covered 100%	◆50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	◆Covered 100%	◆50%
Newborn	◆Covered 100%	◆50%
Urgent Care Clinic	◆Covered 100%	◆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)	◆Covered 100%	◆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)	◆Covered 100%	
Orthodontic Injury Treatment	◆Covered 100%	
Dental Injury Treatment	◆Covered 100%	
TRANSPLANT BENEFIT	YOU PAY	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY	
Diabetic Testing Supplies (90 day supply)	◆Covered 100%	◆50%
Medical Supplies	◆Covered 100%	◆50%
Medical Supplies (office)	◆Covered 100%	◆50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	◆Covered 100%	◆50%
Hearing Aids (\$2,500 per Year)	◆Covered 100%	◆50%
Orthotic Supplies (foot inserts & arch supports)	◆Covered 100%	◆50%
Growth Hormone	◆Covered 100%	◆50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY	
Inpatient Services (non-residential)	◆Covered 100%	◆50%
Residential Treatment (30 days per Year)	◆Covered 100%	◆50%
Outpatient Services	◆Covered 100%	◆50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	◆Covered 100%	◆50%
ADDITIONAL BENEFITS	YOU PAY	
TMJ Syndrome diagnosis & non-surgical treatment	◆Covered 100%	Not Covered
Orthognathic/Mandibular Osteotomy	◆Covered 100%	Not Covered
Total Parenteral Nutrition (TPN)	◆Covered 100%	Not Covered
Initial assessment and diagnosis of Primary Infertility	◆Covered 100%	Not Covered
Reduction Mammoplasty	◆Covered 100%	Not Covered
Autism Applied Behavior Analysis	◆Covered 100%	◆50%

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PROVIDER NETWORK	
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Arizona	Blue Cross® Blue Shield® of Arizona
Outside of Utah and Arizona	First Health

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Non-Preauthorization Provider Sanction	\$500 Reduction in Payment	Not Applicable
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Non-Participating Pharmacy	Not Covered	
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PREVENTIVE SERVICES	YOU PAY	
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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	
Physician Office Visits (primary care)	\$30	♦40%
Physician Office Visits (secondary care)	\$60	♦40%
Physician Office Visits (after hours)	\$60	♦40%
Physician Visits (Inpatient)	♦Covered 100%	♦40%
Physician Visits (Outpatient)	♦Covered 100%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	Covered 100%	♦40%
Injections (office)	Covered 100%	♦40%
Surgery (office)	Covered 100%	♦40%
Surgery (Inpatient)	♦Covered 100%	♦40%
Surgery (Outpatient)	♦Covered 100%	♦40%
Anesthesiology (office)	Covered 100%	♦40%
Anesthesiology (Inpatient)	♦Covered 100%	♦40%
Anesthesiology (Outpatient)	♦Covered 100%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦Covered 100%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦Covered 100%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness)	\$30	♦40%
Chiropractic Therapy (20 visits per Year)	\$30	♦40%
Allergy Testing	Covered 100%	♦40%

Educational Services, Inc. 2023 Contract Year A 3000 5000 100%	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	Covered 100%	◆40%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆Covered 100%	◆40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆Covered 100%	◆40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	◆Covered 100%	◆40%
Medical/Surgical Care (Outpatient)	◆Covered 100%	◆40%
Emergency Room (ER)	\$250	\$250
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	◆Covered 100%	◆40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆Covered 100%	◆40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	Covered 100%	◆40%
Newborn	Covered 100%	40%
Urgent Care Clinic	\$75	◆40%
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)	◆Covered 100%	◆40%
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	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY	
Diabetic Testing Supplies (90 day supply)	\$88	◆40%
Medical Supplies	◆Covered 100%	◆40%
Medical Supplies (office)	Covered 100%	◆40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	◆Covered 100%	◆40%
Hearing Aids (\$2,500 per Year)	◆Covered 100%	◆40%
Orthotic Supplies (foot inserts & arch supports)	◆Covered 100%	◆40%
Growth Hormone	◆Covered 100%	◆40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY	
Inpatient Services (non-residential)	◆Covered 100%	◆40%
Residential Treatment (30 days per Year)	◆Covered 100%	◆40%
Outpatient Services	◆Covered 100%	◆40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	\$30	◆40%
ADDITIONAL BENEFITS	YOU PAY	
TMJ Syndrome diagnosis & non-surgical treatment	◆*50%	Not Covered
Orthognathic/Mandibular Osteotomy	◆*50%	Not Covered
Total Parenteral Nutrition (TPN)	◆*50%	Not Covered
Initial assessment and diagnosis of Primary Infertility	◆*50%	Not Covered
Reduction Mammoplasty	◆*50%	Not Covered
Autism Applied Behavior Analysis	◆Covered 100%	◆40%

Services designated ♦ are subject to first dollar 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
Arizona	Blue Cross® Blue Shield® of Arizona
Outside of Utah and Arizona	First Health

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

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.



Administered by EMI Health
EMI Health Customer Service 801-270-2880 or 1-800-662-5851
Self Funded Employee Medical Benefit Plan

All services are subject to the EMI Health Table of Allowances. There will be no benefit when using a Non-participating Provider. THIS IS A MINIMUM ESSENTIAL COVERAGE PLAN. BENEFITS ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. Read your plan document carefully!

MEC Enhanced 2023 Contract Year	MEC Participating Provider Option
GENERAL INFORMATION	YOU PAY
Benefit Accumulator	Calendar Year
Dependent Age Limit	26
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 (30 day supply)	ACA Preventive Care Mandates - Covered 100% Generic - 10% Preferred - 50% Non-Preferred - Not Covered
Non-Participating Pharmacy	Not Covered
Mail Order (90 day supply)	ACA Preventive Care Mandates - Covered 100% Generic - 10% Preferred - 50% Non-Preferred - Not Covered
Specialty Pharmacy	Not Covered
PREVENTIVE SERVICES	YOU PAY
Routine Physical Exam (1 visit per Year)	Covered 100%
Routine Gynecological Exam (1 visit per Year)	Covered 100%
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%
Routine Well-Baby Exams	Covered 100%
Covered Immunizations	Covered 100%
Routine Vision Exam (1 visit per Year)	Covered 100%
Routine Hearing Exam (1 visit per Year)	Covered 100%
Eligible Preventive Facility Services	Covered 100%
PHYSICIAN & PROFESSIONAL SERVICES	YOU PAY
Convenience Clinic (Max 3 visits per year)	\$20
Physician Office Visits (primary care) (Max 3 visits per year)	\$20
Physician Office Visits (secondary care) (Max 3 visits per year)	\$50
Major Diagnostic Test, CT Scan, MRI, NMR (office) (Max 1 per year)	\$250
Minor Diagnostic Test, Radiology, Lab (office or outpatient) (Max 3 per year)	\$50
Injections (office) (Max 3 per year)	Covered 100%
Surgery (office) (Max 1 per year)	Covered 100%
Anesthesiology (office) (Max 3 per year)	Covered 100%
URGENT CARE CLINIC	YOU PAY
Urgent Care Clinic (Max 3 visits per year)	\$50
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY
Diabetic Testing Supplies (90 day supply)	30%
Medical Supplies (office) (Max 3 per year)	Covered 100%
PROVIDER NETWORK	
Nationwide, except Utah	First Health Limited Benefit Network
Utah	EMI Health MEC Network

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, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.

As an added benefit, in addition to this medical plan, members have access to EMI TeleMed.

TeleMed	YOU PAY
TeleMed	\$0

Group: Educational Services, Inc. (Plan #3823)
Plan: Summit Plus Indemnity
Underwritten & Administered by: EMI Health
Plan Type: Voluntary / Fully Insured
Effective Date: 1/1/2023
Benefit Year: Calendar

	In-Network	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	100%	100% up to R&C
Type 2 - Basic Fillings, Oral Surgery	90%	80% up to R&C
Type 3 - Major Crowns, Bridges, Prosthodontics	60%	50% up to R&C
Type 4 - Orthodontics Dependent children ages 7 through 18	50%	50%
Endodontics	Type 2 - Basic	Type 2 - Basic
Periodontics	Type 2 - Basic	Type 2 - Basic
Sealants	Type 2 - Basic	Type 2 - Basic
Space Maintainers	Type 2 - Basic	Type 2 - Basic
Waiting periods		
Type 2 - Basic	None	
Type 3 - Major	None	
Type 4 - Orthodontics	None	
Deductible	In and Out of Network Deductibles are Combined	
Per Person	\$50.00	\$50.00
Family Max	\$150.00	\$150.00
Deductible Applies To	Type 2 & Type 3	Type 2 & Type 3
Annual Maximum Per Person	\$1,500.00	
Orthodontic Lifetime Maximum	\$1,500.00	
Network (Utah)	Premier (EMI Health)	N/A
Network (Arizona & Outside Utah)	Summit Plus (Cigna)	N/A
Fee Schedule	Summit Plus	R & C (80th)
Monthly Rates		
Employee	\$52.00	
Employee + Spouse	\$108.30	
Employee + Child(ren)	\$116.80	
Employee + Spouse + Child(ren)	\$182.20	
Provisions / Limitations / Exclusions		
Exams (including Periodontal), Cleanings and Fluoride	2 per year	
Fluoride	Up to age 16	
Sealants	Up to age 16	
Space Maintainers	Up to age 16	
Bitewing X-Rays	Up to 4, twice per year	
Periapical X-Rays	6 per year	
Panoramic X-Ray	1 every 3 years	
Impacted Teeth	Covered in Type 2 - Basic	
Anesthesia - (Age 8 and over for the extraction of impacted teeth only)	Covered in Type 3 - Major*	
Anesthesia - (For children age 7 and under, once per year)	Covered in Type 3 - Major*	
Implants / Implant Abutments	Not Covered	
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth	
Fillings on the same surface	1 every 18 months	
Benefits illustrated are in summary only. Refer to your Dental Handbook for a complete description of benefits, limitations and exclusions.		
When using a Non-participating Provider, the insured is responsible for all fees in excess of the Reasonable and Customary Charges (R&C).		
* Anesthesia is not subject to waiting periods.		



Corporate (801)262-7475
Customer Service (800)662-5851
EMIHealth.com

Plan:
Administered by:
Plan Type:
Benefit Year:

Value
EMI Health
Voluntary / Discount Plan
Calendar

	In-Network Only
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	20% to 70% Savings - See Member Schedule (Discount Only)
Type 2 - Basic Fillings, Oral Surgery	20% to 60% Savings - See Member Schedule (Discount Only)
Type 3 - Major Crowns, Bridges, Prosthodontics	20% to 50% Savings - See Member Schedule (Discount Only)
Type 4 - Orthodontics Dependent children ages 7 through 18	Discount Only
Adults	Discount Only
Endodontics	20% to 50% Savings - See Member Schedule (Discount Only)
Periodontics	20% to 50% Savings - See Member Schedule (Discount Only)
Sealants	20% to 60% Savings - See Member Schedule (Discount Only)
Space Maintainers	20% to 60% Savings - See Member Schedule (Discount Only)
Specialists	20% Discount
Waiting periods	
Type 2 - Basic	None
Type 3 - Major	None
Type 4 - Orthodontics	None
Deductible	
Per Person	\$0.00
Family Max	\$0.00
Deductible Applies To	N / A
Annual Maximum Per Person	N / A
Orthodontic Lifetime Maximum	N / A
Network (Utah)	Value (EMI Health)
Network (Arizona & Outside Utah)	Value (Careington)
Fee Schedule	Value
The Program provides discounts only at certain health care providers for health care services; the Program holder is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the Program.	
Member Fees are subject to change January 1st of each year.	



Value (Arizona)
Sample Schedule of Member Fees
Effective 1/1/2022

Corporate (801)262-7475 Customer Service (800)662-5851

emihealth.com

Code	Code Name	Member Fee*
D0120	PERIODIC ORAL EVALUATION - EST PATIENT	27
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	45
D0150	COMP ORAL EVALUATION - NEW OR EST PATIENT	46
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES <i>(Including bitewings)</i>	80
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	15
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	13
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	16
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	25
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	34
D0330	PANORAMIC RADIOGRAPHIC IMAGE	64
D1110	PROPHYLAXIS - ADULT	55
D1120	PROPHYLAXIS - CHILD	39
D1208	TOPICAL APPLICATION OF FLUORIDE EXCL VARNISH <i>(*Verify age limits of the plan)</i>	24
D1351	SEALANT - PER TOOTH <i>(*Verify age limits of the plan)</i>	29
D2140	AMALGAM - ONE SURFACE PRIMARY OR PERMANENT	71
D2150	AMALGAM - TWO SURFACES PRIMARY OR PERMANENT	90
D2160	AMALGAM - THREE SURFACES PRIMARY OR PERMANENT	109
D2161	AMALGAM-FOUR/MORE SURFACES PRIMARY/PERMANENT	133
D2330	RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR	84
D2331	RESIN-BASED COMPOSITE - TWO SURFACES ANTERIOR	105
D2332	RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR	129
D2335	RESIN-BASED COMPOSITE 4/> SURFACES INCISAL ANGLE	152
D2391	RESIN-BASED COMPOSITE - ONE SURFACE POSTERIOR	92
D2392	RESIN-BASED COMPOSITE - TWO SURFACES POSTERIOR	129
D2393	RESIN-BASED COMPOSITE - THREE SURFACES POSTERIOR	159
D2394	RESIN COMPOS - FOUR OR MORE SURFACES POSTERIOR	165
D2740	CROWN - PORCELAIN/CERAMIC	677
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	668
D2751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL	622
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	638
D2920	RE-CEMENT OR RE-BOND CROWN	58
D2950	CORE BUILDUP INCLUDING ANY PINS WHEN REQUIRED	150
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	190
D3120	PULP CAP - INDIRECT <i>(Excluding final restoration)</i>	32
D3220	TX PULP-REMOV PULP CORONAL DENTINOCEMENTL JUNC	98
D3310	ENDODONTIC THERAPY ANTERIOR TOOTH <i>(Excluding final restoration)</i>	411
D3320	ENDODONTIC THERAPY PREMOLAR TOOTH <i>(Excluding final restoration)</i>	501
D3330	ENODODONTIC THERAPY MOLAR TOOTH <i>(Excluding final restoration)</i>	647
D4341	PRDONTAL SCALING&ROOT PLANING 4/MORE TEETH-QUAD	136
D4355	FULL MOUTH DEBRID ENABLE COMP ORAL EVALUATION&DX ON A SUBSEQUENT VISIT	92
D4381	LOC DEL ANTIMICROBL AGTS CREVICULR TISS TOOTH BR	20% Discount
D4910	PERIODONTAL MAINTENANCE	84
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	577
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	658
D7111	EXTRACTION CORONAL REMNANTS - DECIDUOUS TOOTH	75
D7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT <i>(Elevation and/or forceps removal)</i>	90
D7210	SURG REMOVAL ERUPTED TOOTH REMV BONE ELEV FLAP	159
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	239
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	280
D7810-D7899	TMD THERAPY	20% Discount
D9110	PALLIATIVE EMERGENCY TX DENTAL PAIN MINOR PROC	58
D9230	INHALATION OF NITROUS OXIDE/ANXIOLYSIS ANALGESIA	32

*Member Fees apply to General Dentists only. Specialists provide a 20% discount off of billed charges.



Group: Educational Services, Inc. (Plan #3823)
Plan: VSP Plus 10-130
Effective Date: 1/1/2023
Plan Type: Voluntary

	In-Network	Out-of-Network
Network	VSP Choice Plus	
WellVision Exam	\$10 Co-pay	Up to \$65
Lenses (Glass or Plastic)		
Single Vision	\$10 Co-pay	Up to \$30
Lined Bifocal	\$10 Co-pay	Up to \$50
Lined Trifocal	\$10 Co-pay	Up to \$65
Lenticular	\$10 Co-pay	Up to \$100
Lens Options		
Progressive (Standard no-line)	\$0 Co-pay	Up to \$50 (In lieu of Lined Bifocal reimbursement)
Premium Progressive Options	\$95-\$105 Co-pay	
Custom Progressive Options	\$150-\$175 Co-pay	
Plastic Gradient Dye	\$17 Co-pay	N/A
Solid Plastic Dye	\$15 Co-pay	
Photochromic Lenses	\$75 Co-pay	
Polycarbonate for Adults	\$31 Co-pay SV/\$35 Co-Pay Multifocal	
Polycarbonate for Children (under 18)	\$0 Co-pay	
Coatings		
Scratch Resistant Coating	\$17 Co-pay	N/A
Anti-Reflective Coating	\$41 Co-pay	
UV Protection	\$16 Co-pay	
Additional lens enhancements	Up to 25% Discount	
Frames		
Allowance Based on Retail Pricing	\$130 Allowance at any VSP doctor or \$70 at Costco, Sam's Club or Walmart	Up to \$80
Additional Pairs of Glasses**	Up to 20% Off Retail	N/A
Elective Contact Lenses In Lieu of Frame & Lenses		
Elective contact lens fitting, evaluation services and prescription contact lenses are covered up to plan allowance. 15% discount given off contact lens fitting and evaluation services, excluding materials.	\$130 Allowance	Up to \$115
Frequency		
Exam, Lenses, Frame or Contacts	Every 12 Months	
Refractive Surgery		
LASIK***	Up to \$500 in Savings	Not Covered
Monthly Rates	Voluntary	
Employee	\$10.40	
Employee + Spouse	\$22.20	
Employee + Child(ren)	\$23.90	
Employee + Spouse + Child(ren)	\$34.10	
Notes		
This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.		
** 20% discount off unlimited additional pairs of glasses offered through any VSP Choice Providers within 12 months of last covered eye exam.		
*** Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, Custom LASIK, and IntraLase3		

Underwritten by: EMI Health



Plan:
Plan Type:

VSP Vision Savings Pass
Voluntary or Contributory

In-Network	
Network	VSP Choice
WellVision Exam	\$50 with purchase of a complete pair of prescription glasses ¹
Contact Lens Exam	15% savings on a contact lens exam ²
Retinal Screening	Guaranteed pricing with WellVision Exam, not to exceed \$39
Lenses (Glass or Plastic)	
Single Vision	\$40 with purchase of a complete pair of prescription glasses
Lined Bifocal	\$60 with purchase of a complete pair of prescription glasses
Lined Trifocal	\$75 with purchase of a complete pair of prescription glasses
Polycarbonate for Children (under 18)	\$0 with purchase of a complete pair of prescription glasses
Lens Enhancements	
Progressive	Average savings of 20-25%
Scratch-Resistant	Average savings of 20-25%
Anti-Reflective	Average savings of 20-25%
Frames	25% savings when a complete pair of prescription glasses is purchased
Sunglasses	20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last WellVision Exam.
Frequency	
Exam, Lenses, Frame or Contacts	Eye exam is limited to once per calendar year per member. Unlimited use on materials.
Notes	
VSP Vision Savings Pass is a discount vision program that offers immediate savings. This is not an insurance plan.	
1. This cost is only available with the purchase of a complete pair of prescription glasses; otherwise, you'll receive 20% savings on an eye exam only.	
2. Applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost.	

TeleMedicine

Reach a doctor 24/7/365

Some 70% of doctor visits can be handled over the phone, and 40% of urgent care visits can be managed using TeleMedicine. Save time and money while still getting the treatment you need through EMI Health TeleMed offered through WellVia.

When to Use TeleMed

WellVia doctors diagnose acute, non-emergent medical conditions and prescribe medications when clinically appropriate.

Speak with a doctor anytime and pay no consultation fee rather than paying the high costs associated with office visits, urgent care visits, and emergency room visits.

Just call **1-877-872-0370**.

Video consultations are available as well from 7 AM - 7 PM.

Common Conditions

- Acid Reflux
- Allergies
- Asthma
- Bladder Infection
- Bronchitis
- Cold & Flu
- Constipation
- Cough
- Ear Pain*
- Fever
- Gout
- Headache
- Hemorrhoids
- High Blood Pressure
- Joint Pain
- Nausea
- Pink Eye
- Rashes
- Sinus Conditions
- Sore Throat
- Stomach Virus
- Thyroid Conditions
- Urinary Tract Infections
- Yeast Infections

**In accordance with telemedicine guidelines, ear infections are only diagnosed for patients that are 18 years of age or older.*

Common Medications

- Albuterol
- Allegra
- Asthma
- Flonase
- Ibuprofen 800 mg
- Levaquin
- Lipitor
- Nasonex
- Many Others

WELLVIA
1-877-872-0370



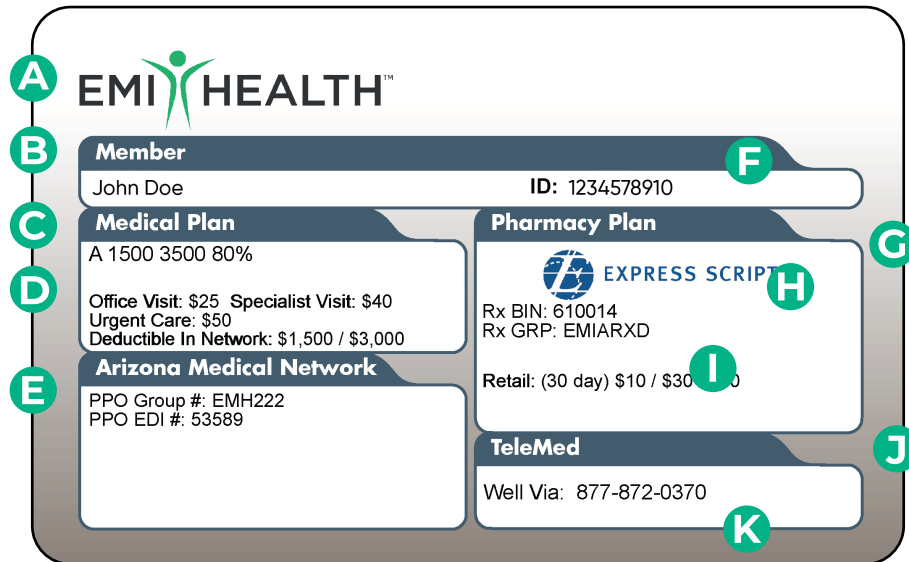
**Download the
WellVia mobile app**

Your ID Card (front)

It is important that you present your ID card each time you receive services.

Your EMI Health ID card contains a lot of useful information for you and your provider.

Card Front



A EMI Health is your insurance carrier.

B The employee's name is listed on the ID card. Covered dependents are not listed.

C This is the name of your medical plan and also indicates your participating provider network. To verify a provider's status, visit emihealth.com or call 800-662-5851.

D These are your basic copay, coinsurance, and deductible amounts when you visit a participating provider. For more detailed benefits information, see your Summary of Benefits and member handbook.

E This is your medical participating provider network when traveling outside of Utah. To verify a provider's status, visit emihealth.com or call 800-662-5851.

F Your unique member number is required in order to verify coverage, determine benefits, and pay claims for you and your dependents.

G Express Scripts is your Pharmacy Benefits Manager.

H These are your basic pharmacy copays and coinsurance amounts.

I If you have dental coverage with EMI Health, the name of your dental plan will appear here. This also indicates your dental participating provider network. To verify a provider's status, visit emihealth.com or call 800-662-5851. If this section is not on your card, you do not have dental coverage through EMI Health.

J If you have vision coverage with EMI Health, the name of your vision plan will appear here. This also indicates your vision participating provider network. To verify a provider's status, visit emihealth.com or call 800-662-5851.

If this section is not on your card, you do not have vision coverage through EMI Health.

K This is the phone number to call for a Telemed consultation with a WellVia physician. EMI Telemed can eliminate the need for office visits for many common conditions.

If this section is not on your card, you do not have TeleMed services through EMI Health.

Your ID Card (back)

Card Back

A **Claims Submission**

Medical Claims in AZ: BCBSAZ providers/facilities in Arizona must submit EDI claims to BCBSAZ using EDI # 53589 or PO Box 2924, Phoenix, AZ 85062-2924.

Arizona Network provided by Blue Cross® Blue Shield® of Arizona (BCBSAZ), an independent licensee of the Blue Cross and Blue Shield Association. BCBSAZ provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

All Other Claims
EMI Health Payer ID: SX110
or PO Box 21482
Eagan, MN 55121

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

B **Customer Service**

1-800-662-5851
cs@emihealth.com
www.emihealth.com

Underwritten or Administered by EMI Health

Outside of UT & AZ Medical Networks

C **EMI HEALTH**
Smart Benefits In Utah

D **Pre-Authorizations**

This card does not guarantee coverage. Please confirm eligibility and benefits prior to services.

Prior authorization is required for inpatient admission, outpatient surgery and other services prior to receiving care or within 48 hours in an emergency. See plan for full list.

Pre-authorizations: Call 800-662-5851 or email preauthorization@emihealth.com

E **First Health Network**
A medical provider network outside of Arizona and Utah

A This is the claims submission address for Utah medical claims and all dental claims. In most cases, your provider will submit claims directly to EMI Health.

C These are your participating provider medical networks for Utah and nationally. To verify a provider's status, visit emihealth.com or call 800-662-5851.

E These are your participating provider dental networks outside of Utah. To verify a provider's status, visit emihealth.com or call 800-662-5851.

B This is the telephone number to call for customer service inquiries.

D This is the telephone number to call for preauthorizations.

If this section is not on your card, you do not have dental coverage through EMI Health.

Reading Your EOB



EMI Health
5101 South Commerce Drive
Murray UT 84107

J148 [1] 1 of 1



How To Read Explanation of Benefits

Forwarding Service Requested

*****SGLP
1 1 SP 0.490
JOE SAMPLE
123 MAIN ST
ANYTOWN, USA 12345

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

①

Customer Service

8:00 am to 6:00 pm MST Monday through Friday
Customer Service and Benefit Inquires call
(Local)(801)262-7475(Toll Free)(800)662-5851
(Fax)(801)269-9734

Employer Group: GROUP ABC
Date Processed: 05/09/2018

This is an explanation of how your claim was processed by EMI Health. If you have questions about payments, contact your provider.

Patient: JOE SAMPLE		Provider:ABC Hospital								
Claim #: 215-000111111-00		Subscriber:JOE SAMPLE					Subscriber #: 123456789			
② Service Dates	③ Description of Service	④ Billed	⑤ Allowed	⑥ Provider Discount	⑦ Not Covered	⑧ Reason Code	⑨ Deductible	⑩ Coinsurance	⑪ Co-pay	⑫ Payment
04/03-04/03/2018	Minor diagnostic testing (outpatient)	\$677.79	\$474.45	\$203.34	\$0.00	05	\$474.45	\$0.00	\$0.00	\$0.00
Column Totals		\$677.79	\$474.45	\$203.34	\$0.00		\$474.45	\$0.00	\$0.00	\$0.00
⑬ Other Insurance Credits or Adjustments										\$142.56
⑭ Total Payment Amount										\$0.00
⑮ Member Responsibility										\$474.45

This is an explanation of how your claim was processed by EMI Health. If you have questions about payments, contact your provider.

Patient: JOE SAMPLE		Provider: ABC Hospital								
Claim #: 215-000222222-00		Subscriber: JOE SAMPLE					Subscriber #: 123456789			
② Service Dates	③ Description of Service	④ Billed	⑤ Allowed	⑥ Provider Discount	⑦ Not Covered	⑧ Reason Code	⑨ Deductible	⑩ Coinsurance	⑪ Co-pay	⑫ Payment
04/07-04/07/2018	Major diagnostic testing (outpatient)	\$907.50	\$385.84	\$521.66	\$0.00	05 49	\$25.55	\$0.00	\$100.00	\$0.00
Column Totals		\$907.50	\$385.84	\$521.66	\$0.00		\$25.55	\$0.00	\$100.00	\$0.00
⑬ Other Insurance Credits or Adjustments										\$69.18
⑭ Total Payment Amount										\$0.00
⑮ Member Responsibility										\$125.55

Plan Year Accruals

⑯

Description	Claim Year	Amount Met
JOE SAMPLE Medical Individual Network Deductible - Participating	2018	\$500.00
JOE SAMPLE Medical Individual Network Out-of-Pocket - Participating	2018	\$100.00
Medical Family Network Deductible - Participating	2018	\$500.00

The Amounts listed above are subject to change due to claim adjustments and/or the order in which claims are received.

Explanation of Codes

⑰

05 Negotiated discount has been applied.
49 Service copayment applied.

Reading Your EOB

Benefits Determination

(18)

Read this carefully - this is your notice of payment or nonpayment of claims.

In accordance with the provisions of your plan, you may appeal for reconsideration of any denied portion of this claim by writing to the Administration Office (address above). You should state the reason you believe your claim should be paid, attaching any documentation to support your appeal. The Administrator will consider and respond to your appeal within the time required by your plan. You should review your Plan Summary for specific directions on how and when an appeal must be filed.

Any request for a review of this claim must be received by EMI Health within 180 days of the date of this Explanation of Benefits. You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to this claim. If agreement is not reached after exhaustion of the claims review process outlined in your member handbook, you may have the right to submit the matter to voluntary binding arbitration or independent review or to pursue civil action. If you are covered by more than one health plan, you should file all your claims with each plan.

EMI Health now offers a full selection of Medigap & Medicare Prescription Drug Plans. Call us or visit www.emihealth.com and click on the Medicare Products tab for more information.

Claim Summary

(19)

Claim #	Patient	Billed	Allowed	Provider Discount	Not Covered	Deductible	Coinsurance	Copay	Payment
215-000111111-00	JOE SAMPLE	\$677.79	\$677.79	\$203.34	\$0.00	\$474.45	\$0.00	\$0.00	\$0.00
215-000222222-00	JOE SAMPLE	\$907.50	\$907.50	\$521.66	\$0.00	\$25.55	\$0.00	\$100.00	\$0.00
Totals:		\$1,585.29	\$1,585.29	\$725.00	\$0.00	\$500.00	\$0.00	\$100.00	\$0.00

How To Read EOB

- Customer Service:** If you have questions, please call us at the toll free number listed at the top of your Explanation of Benefits. Our friendly and knowledgeable representatives are here to assist you.
- Service Dates:** Represents the date(s) the patient received services.
- Description of Service:** Lists the procedure performed.
- Billed:** This is the billed amount before any negotiated adjustments, co-pays, deductibles or any ineligible amount.
- Allowed:** The amount allowed by the provider contract.
- Provider Discount:** The amount discounted.
- Not Covered:** Any specific amount that was determined to be ineligible for payment by the plan.
- Reason Code:** This code is used to explain the reason for an adjustment or benefit limitation.
- Deductible:** This amount reflects the deductible requirement at the time charges were processed.
- Coinsurance:** Percentage of allowed amount for which the patient is responsible.
- Co-Pay:** Represents amounts responsible to the patient.
- Payment:** Total amount less any adjustments.
- Other Insurance Credit or Adjustments:** The amount paid by another health plan or insurance company toward services the member received.
- Total Payment Amount:** Total amount less any adjustments.
- Member Responsibility:** This is the total amount that you owe the provider. This includes any co-payments, deductibles, co-insurance and/or excluded charges.
- Plan Year Accruals:** The amount of money you have paid to date for health care services.
- Explanation of Codes:** This code is used to explain the reason something is not covered or is discounted from the billed amount.
- Benefits Determination:** This will be the procedure and information needed to file a formal review for any denied claim.
- Claim Summary:** Provides a summary of claims processed during an extended timeframe.

Preventive Care

Detect potential problems early.

The Affordable Care Act (ACA) provides for certain preventive services to be covered 100 percent when received by participating providers.

Preventive services are those provided when no symptoms or diagnosed medical conditions exist. For services to be covered as preventive, your doctor must bill claims with preventive codes. If a preventive service identifies a condition that needs further testing or treatment, regular copayments, coinsurance, or deductibles may apply.

Here are some preventive services covered with no patient cost:

- Routine physical exam
- Routine vision exam
- Routine hearing exam
- Routine gynecological exam
- Routine Pap smear
- Screening mammogram
- Screening colonoscopy or Cologuard
- FDA-approved contraception

Immunizations recommended by the Advisory Committee on Immunizations Practices of the Center for Disease Controls and Prevention (CDC) are covered 100 percent if received from a participating provider. As of June 2021, those recommendations are as follows:

Children

VACCINE	Birth	1 Mo	2 Mo	4 Mo	6 Mo	12 Mo	15 Mo	18 Mo	19-23 Mo	2-3 Yrs	4-6 Yrs	7-10 Yrs	11-12 Yrs	13-18 Yrs
Hepatitis B	HepB	HepB				HepB							HepB Catch Up	
Rotavirus			RV	RV	RV									
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP				DTaP	DTaP Catch Up	DTaP	DTaP Catch Up
Haemophilus Influenzae Type b			Hib	Hib	Hib		Hib							
Inactivated Poliovirus			IPV	IPV		IPV					IPV		Poliovirus Catch Up	
Measles, Mumps, Rubella						MMR					MMR		MMR Catch Up	
Varicella						Varicella					Varicella		Varicella Catch Up	
Pneumococcal			PCV	PCV	PCV	PCV								
Influenza											Influenza (Yearly)			
Hepatitis A						HepA (2 Doses)							HepA Catch Up	
Meningococcal													MenACWY	MenACWY
Human Papillomavirus													HPV	HPV Catch Up

Adults

VACCINE	19-26 Yrs	27-49 Yrs	50-59 Yrs	60-64 Yrs	≥ 65 Yrs
Diphtheria, Tetanus, Pertussis (Td/Tdap)	One dose of Tdap; then boost with Td every 10 years				
Influenza	One dose annually				
Pneumococcal	1 or 2 doses				1 dose
Zoster (Shingles)		2 doses after age 50			
IF NOT RECEIVED AS A CHILD					
Measles Mumps, Rubella	MMR				
Human Papillomavirus	HPV				
Varicella	Varicella				

Major Diagnostic Testing

Preauthorization Guidelines

Benefit preauthorization to confirm medical necessity is required for **ALL in-patient** confinements and surgeries as part of our commitment to help ensure all EMI Health members get the appropriate care, at the appropriate time, and in the appropriate setting.

In addition, **some major out-patient diagnostic testing** like MRIs, CT scans, PET scans and certain outpatient surgical procedures may also require preauthorization. Please have your provider's office contact EMI Health's customer service for preauthorization codes prior to any services being rendered.

EMI Health continually monitors procedures requiring preauthorization and makes adjustments as necessary.

Recent updates

For the new plan year (plans renewing on or after 07/01/2020), major diagnostic tests will require preauthorization.

Important member details

As a reminder, if the member uses a participating provider, the provider (not the member) is responsible for preauthorization.

If the member uses a non-participating provider for treatments or procedures requiring preauthorization, the member is responsible for obtaining preauthorization, and benefits may be denied or reduced if preauthorization is not obtained.

Refer to the plan document for more information regarding preauthorization.

A heartfelt thank you

We appreciate the opportunity of providing your healthcare coverage.

If you have any questions about this notice, please do not hesitate to call or email us.

Phone: 800.662.5851

Email: cs@emihealth.com

Please note: First Health, Blue Cross Blue Shield of AZ, and Cigna all have different preauthorization requirements.



Diabetes Management

Your medical plan covers diabetic equipment and supplies under the major medical benefit and/or Prescription Drug (Pharmacy) Benefit. Contact customer service for the specifics of your plan. Here are some common coverages.

Diabetic Testing Supplies

Diabetic testing supplies, such as blood sugar (glucose) test strips, and lancets, may be covered through your Major Medical or Prescription Drug Benefit:

Major Medical Benefits

Coverage falls under the Medical Supplies & Equipment benefit. Refer to the Diabetic Testing Supplies line item of your Schedule of Benefits for your member cost share.

The following suppliers are participating providers on EMI Health plans. If you obtain supplies through any other medical provider or facility, benefits are subject to your Non-Participating Provider benefit option, if any.

- Byram Healthcare - 800-775-4372
- Edgepark / Cardinal - 877-215-2568
- JQ Medical Supply - 801-942-8582

Prescription Drug (Pharmacy) Benefit

Refer to the Prescription Drug section of your Schedule of Benefits for your member cost share.

The 2022 formulary includes OneTouch and Freestyle. All other brands are excluded from coverage.



Continuous Glucose Monitoring Systems (CGMS) and Sensors

CGMS and sensors may be covered through your Major Medical or Prescription Drug Benefit, subject to preauthorization criteria and plan review. Refer to the Durable Medical Equipment and Prescription Drug sections of your Schedule of Benefits for your member cost share.

Insulin Pump and Insulin Pump Supplies

Insulin pumps are covered through your Major Medical Benefit, subject to preauthorization criteria and plan review. Refer to the Durable Medical Equipment section of your Schedule of Benefits for your member cost share.

Insulin pump supplies (cartridges and infusion sets) may be covered through your Major Medical or Prescription Drug Benefit. Refer to the Durable Medical Equipment and Prescription Drug sections of your Schedule of Benefits for your member cost share.

Insulin

Insulin is covered under the Prescription Drug Benefit. You may receive up to a 30-day supply per retail copayment or up to a 90-day supply per mail-order copayment. Refer to the Prescription Drug section of your Schedule of Benefits for member cost share.

Preferred insulin copayments will be capped at \$25 per 30-day supply and \$75 per 90-day supply through the Cigna/Express Scripts Patient Assurance Program.

Preferred insulins are Humalog, Humulin, and Semglee.

Prescription Drugs

Prescription drugs are covered under the Prescription Drug Benefit. This includes Glucagon, GLPI agents (e.g., Byetta, Bydureon, and Tradjenta), and oral agents for Type 2 diabetes (e.g., Glucophage, Avandia, and Amaryl). Refer to the Prescription Drug section of your Schedule of Benefits for member cost share.

Blood sugar testing monitors, glucose control solutions, and weight loss medications are NOT covered under the Major Medical or Prescription Drug Benefits.

Questions?

As always, we are here to help. **Call customer service at 800-662-5851**

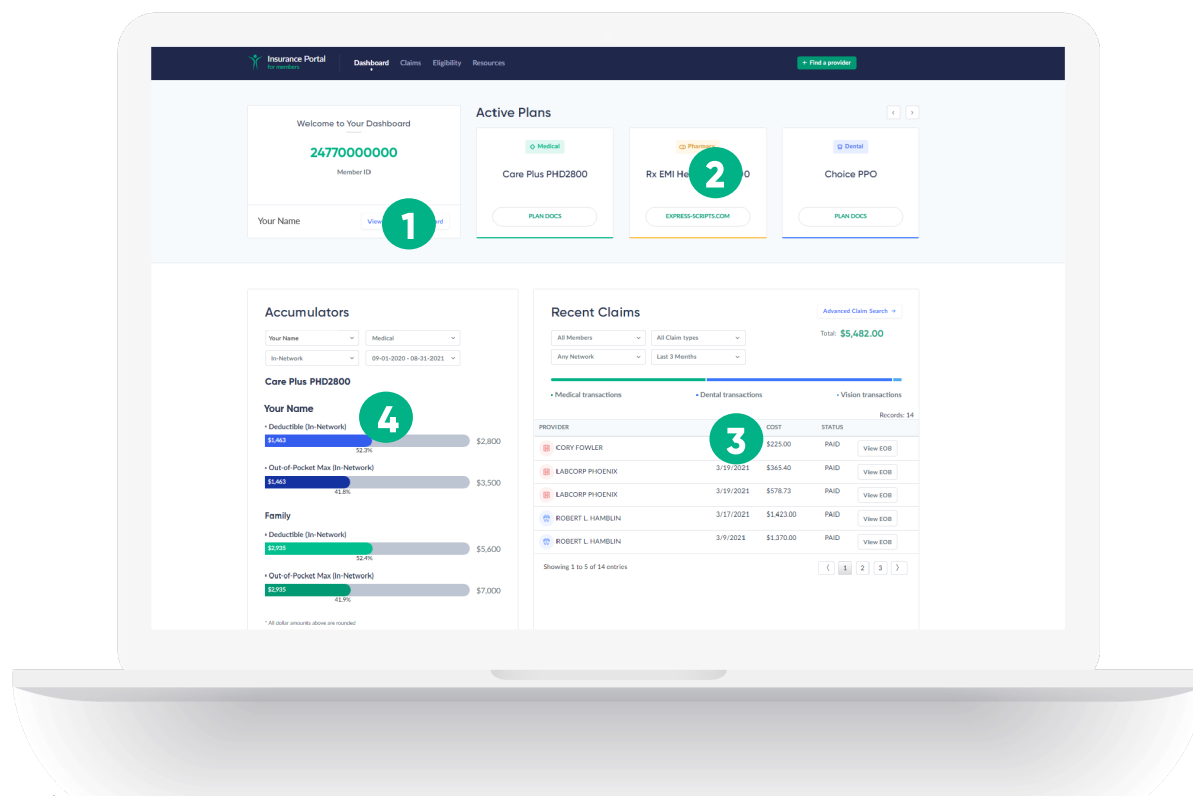


My EMI Health Account

Welcome to your member dashboard! In less than 30 seconds, you can see everything you need to know.

Let's take a tour of your dashboard

Note: not all of these blocks may appear on your dashboard. This guide covers all that may possibly show up, but they may not apply to the EMI Health plans you are enrolled in.



1 View your member ID card

View, download, or print your EMI Health ID card by clicking on "View Your Member ID Card" button.

2 See your plan documents

Here are the plans you are currently enrolled in through EMI Health. From here, you can view your plan documents (your coverage grids and/or fee schedules if applicable) and access your pharmacy tools.

3 View and sort your recent claims

Use the toggles to filter and sort your claims by type, covered member, network, and date range. View your **Explanation of Benefits (EOBs)** documents by clicking on "View EOB" to the right of each claim. *Note: These documents are not mailed, so it's important to check your dashboard regularly for any new EOBs that come into your account.*

4 At-a-glance accumulators

In this block, you are able to see your progress towards applicable plan accumulators for medical and dental plans. Use the drop down options at the top to switch between covered members on your plan, time period, and accumulator type.

Bonus tools included with your account

Below your account tools, you can scroll through some additional tools included with your plan to help you save money and get the most out of your EMI Health benefits. *(What you will see in your dashboard depends on the plans you are currently enrolled in with EMI Health.)*



\$0 Copay TeleMed

You can speak to a board-certified physician for FREE anytime, anywhere. You can save money and time by avoiding the doctor's office, urgent care, and emergency room visits for acute, non-emergency illnesses or injuries.



Be Well - Wellness Platform powered by WebMD

Be Well puts you in the driver's seat when it comes to your health and wellness goals. Your platform is customized to your health profile and your interests, so the resources, challenges, and recommendations you can access in this platform are tailored to you.



Smart Cost Calculator

You can easily see the estimated cost of procedures, services, and prescriptions before you go, empowering you to make the smartest decisions for your health care.

Setup your My EMI Health Account

If you haven't set up your My EMI Health account yet, here are the instructions:

- Go to **emihealth.com**.
- Click **Login** and select My EMI Health.
- Select **Register** and choose **Member** as the type of account.
- Enter the data to identify yourself and click **Continue**.

** You will need your Member ID found on your EMI Health ID card. Also, for your security, your password must be at least six characters and include a special character, e.g., !, @, #, \$, etc.*

***Please note that you will only make an EMI Health account for your family through the plan subscriber. Dependents and spouses will not have their own account.*

Finding a Provider

Using in-network providers and facilities gets you the most coverage for healthcare services and saves you money.

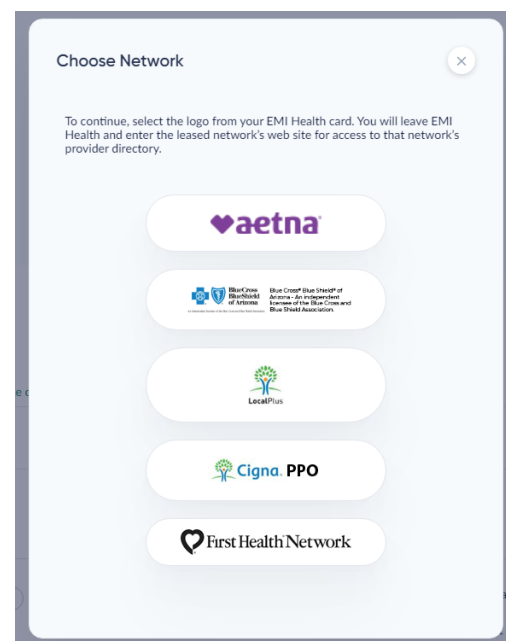
Blue Cross® Blue Shield® of Arizona Provider Search

As a member of EMI Health, you have access to a great network of doctors, hospitals, and other facilities.

To find an in-network provider, follow these simple steps.

- 1 **Go to emihealth.com**
Click on **Find a Provider** along the upper part of the home page.
- 2 **Enter your plan name and state**
Choose **medical** as the type of provider, choose **Care Plus** as your plan name, and select your state from the drop-down list.
- 3 **Click on the Blue Cross® Blue Shield® of Arizona logo**
When you see this pop-up, click on the BCBSAZ logo to be redirected to their provider search tool.
- 4 **Customize your search**
Now, choose a plan (**Arizona PPO or Mayo Clinic**) and click Find a Doctor.

From here, you'll enter your location and search doctors, hospitals, and more.



That's all there is to it!

You will see a list of participating providers along with contact information, address, and the ability to map the location of their offices. You can also download the results as a PDF to keep or take with you.

Traveling outside Arizona?

Searching outside Arizona and Utah: If you are outside Arizona and Utah, First Health has you covered. Follow steps 1 & 2 above, and choose the First Health logo when you see the pop-up. This will take you to First Health's website. Click on **Start now**. Then, mark what you'd like to search (physician, hospital, urgent care center, etc.), hone in with the geography filters, and hit **Search now** to find your providers.

Searching in Utah: Enter your location on the EMI Health provider search tool, selecting Utah as your state. You will then be taken to the results page, and you can then filter by specialties, locations, languages, and more. You can map the provider's location, get contact information, and download your results to a PDF.

Looking for dental and vision providers?

It's easy to find in-network dental and vision providers near you using the EMI Health Provider Search tool.

1

Go to emihealth.com

Click on [Find a Provider](#) along the upper part of the home page.

2

Select the type of provider

Select dental or vision.

3

Enter your plan name (found on your ID card)

These are the plan options you will see.

Dental	Vision
Premier (Choice)	Opticare
Advantage/Advantage Plus (Choice)	VSP Choice
Value	VSP Choice Plus
Summit*	
Summit Plus*	

**If you have the Summit or Summit Plus dental plans, you will be redirected to Cigna's dental provider search.*

4

Enter your location information and click "Search"

You can also select ["Use My Location."](#) This feature will automatically populate the state and zip code where you are searching.

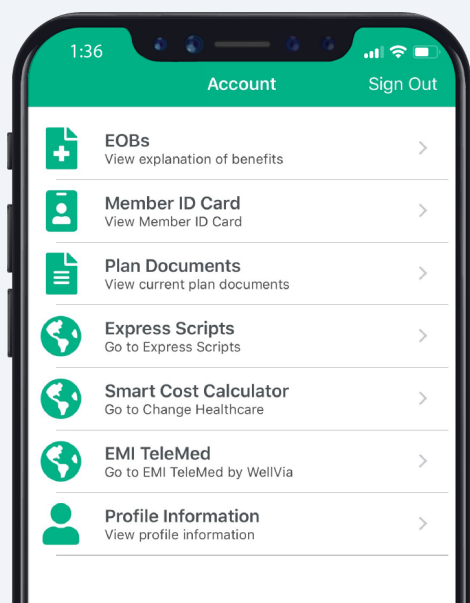
5

Filter and sort your results

Now you can filter your results for locations, specialties, facilities, languages, and more. Click ["Search"](#) each time you adjust a filter to refresh the results list.

That's all there is to it!

You will see a list of participating providers along with contact information, address, and the ability to map the location of their offices. You can also download the results as a PDF to keep or take with you.



Search on the go

In addition to being another convenient way to search for providers and facilities, the EMI Health mobile app allows you to do even more.

Access your ID Card

View and download your plan grids so you always know the benefits you have.

View your EOBs and search by person, service, date, and more.

Update your profile information like email address, password, or security questions.

The EMI Health Mobile App

Your benefits. Anytime. Anywhere.

Provider Search

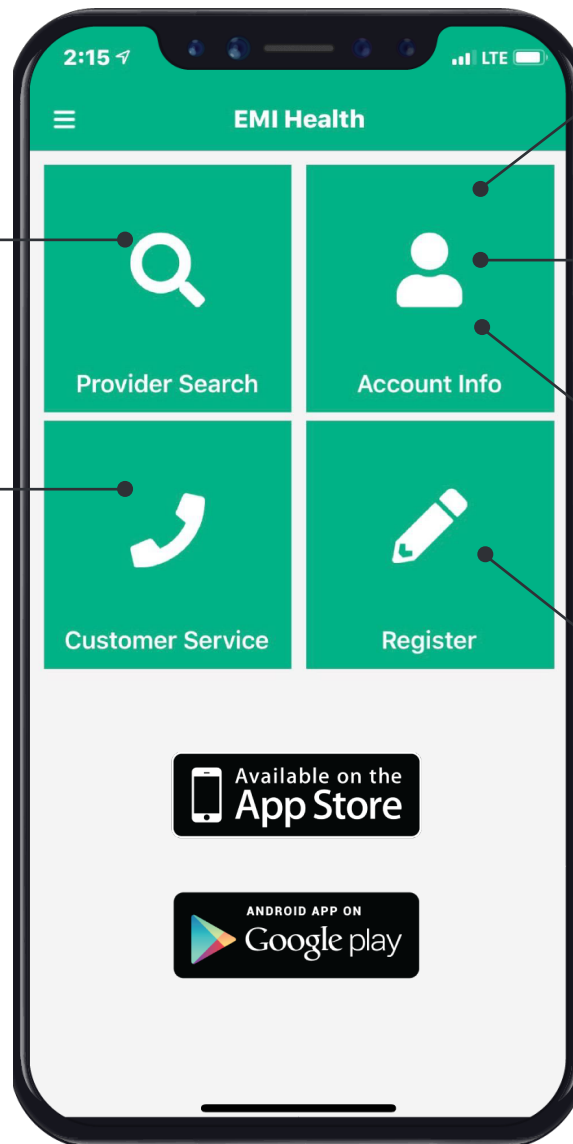
Find in-network providers and facilities.

Customer Service

Need to talk to a person?
No problem.
Call us from the app.

Other Features

- Access current and past issues of the Hope Health newsletter.
- Update your profile information like email address, password, or security questions.



ID Card

Access your ID Card from anywhere at any time.

EOBs

View your EOBs and search by person, service, date, and more.

Plan Information

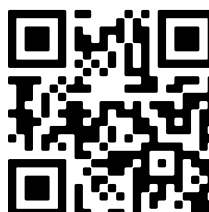
View and download your plan grids so you always know the benefits you have.

Log in/Register

Download the app and log in using your My EMI Health username and password.

If you haven't registered your account, you can do so in the app or online at emihealth.com.

Scan this QR code
with your phone
to download.



Be Well

A wellness program specifically tailored for every individual's unique goals

EMI Health has teamed up with WebMD Health Services to create a comprehensive well-being tool that puts you in the driver's seat when it comes to your health and wellness goals.

Each view into the BE WELL platform is unique. The customized dashboard is based on your individual priorities, health risks, and biometric testing data. As a result, it's completely tailored to your needs and continues to evolve over time as your priorities and health conditions change. The BE WELL tools can help you focus on areas such as weight loss, stress management, nutrition, improving your sleep habits, and tobacco cessation.

Eligible EMI Health subscribers* who currently have a medical plan can access BE WELL through the member portal at emihealth.com. *A subscriber is the main account holder whose name appears on the EMI Health ID card. Dependents are not eligible to participate at this time.

A look at the BE WELL digital platform

Track Personal Health

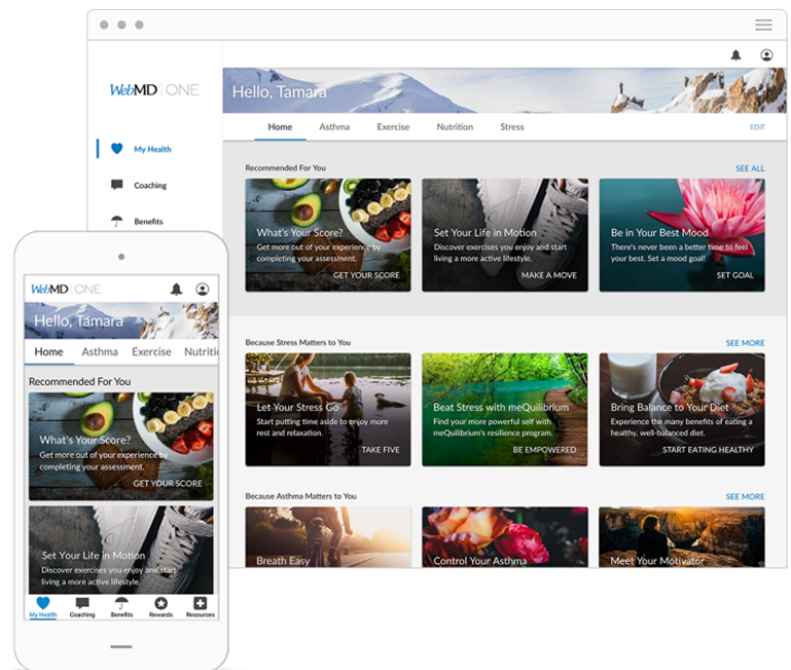
Receive a report on your current health, along with recommended steps to improve it. Whether you want to spend more time focusing on general well-being or a specific health condition, you will have the ability to choose your own priorities, and your personalized dashboard will reflect those interests.

Manage Specific Health Conditions

If you happen to have a specific health condition or concern, BE WELL can provide a recommended plan to help manage that condition as well as educational materials to help you better understand it. BE WELL can help manage diabetes, high blood pressure, hypertension, COPD, and many others.

Reevaluate Your Priorities at Anytime

As you track your personal progress you can make adjustments to the program. At any time along your journey you can switch gears and let BE WELL know you're interested in a new area of focus. If you feel like you have conquered one major milestone, then keep going and strive to reach another. With BE WELL, you can achieve what matters most to you.



Set Goals and Work on Daily Habits

The Daily Habits tool uses the power of behavioral science to help you achieve your personal well-being goals and implement lifestyle changes. You can choose from a number of categories to help with things like diet and nutrition, stress management, depression, and even staying connected in your social life. Resources like workout routines, recipes, and food journals can help encourage you to stay motivated, track your progress and achieve real results.

90-Day Maintenance Medications

Get a 90-day supply of maintenance medications at any participating pharmacy or have them delivered directly to your home!

How Does the 90-Day Retail Fill Work?

1. Ask your doctor for a prescription for a 90-day supply (plus refills, as applicable).
2. Take your prescription to any participating pharmacy.
3. You will pay three times the 30-day retail copayment for your plan. The exact amount you pay will depend on whether your medication is generic, preferred, or non-preferred brand. Please refer to your Summary of Benefits for the details of your plan.

How Does Mail Order Work?

1. Ask your doctor for a prescription for a 90-day supply (plus refills, as applicable).
2. If you need to start taking the medication right away, ask for another prescription for up to a 30-day supply to be filled at a retail pharmacy.
3. Send the 90-day prescription, along with the completed mail-order form (which can be downloaded from www.emihealth.com) and the appropriate copayment, to Express Scripts at the address on the form. (You may also ask your doctor to fax your order to Express Scripts.)
4. You will pay the Mail-order Copayment amount indicated on your Summary of Benefits. The exact amount will depend on whether your medication is generic, preferred, or non-preferred brand.
5. Express Scripts will process the order and return it via U.S. Mail or UPS, along with instructions for future refills. Allow up to 14 days for delivery from the time you mail the prescription.

Questions?

As always, we are here to help.

Call customer service at 1-800-662-5851.





2022 Express Scripts National Preferred Formulary

KEY

[INJ] - Injectable Drug
Brand-name drugs are listed
in CAPITAL letters.
Generic drugs are listed
in lower case letters.

A

ABILIFY MAINTENA [INJ]
acetaminophen/codeine
ACTEMRA [INJ]
acyclovir
ADEMPAS
ADVAIR HFA
ADVATE [INJ]
ADYNOVATE [INJ]
AFSTYLA [INJ]
AIMOVIG [INJ]
AJOVY [INJ]
albuterol nebulization solution
albuterol sulfate hfa
(by Cipla, Lupin, Par,
Perrigo, Proficient Rx,
Sandoz & Teva)
ALECENSA
alendronate
allopurinol
alprazolam
ALUNBRIG
amiodarone
amitriptyline
amlodipine
amlodipine/benazepril
amlodipine/valsartan
amoxicillin
amoxicillin/potassium
clavulanate
anastrozole
ANDRODERM
ANORO ELLIPTA
ARALAST NP [INJ]
ARIKAYCE
aripiprazole
ARISTADA [INJ]
ARNUVITY ELLIPTA
ASMANEX HFA
ASMANEX TWISTHALER
atenolol
atenolol/chlorthalidone
atomoxetine
atorvastatin
AUBAGIO
AUSTEDO
AVONEX [INJ]
AZASITE
azelastine nasal spray
azithromycin

B

baclofen
BAFIERTAM
BAQSIMI
BARACLUDE SOLUTION

BAXDELA
BD AUTOSHIELD
DUO NEEDLES
BD ULTRAFINE
INSULIN SYRINGES
BD ULTRAFINE PEN NEEDLES
BELBUCA
benazepril
benzonatate
BETASERON [INJ]
BEVESPI AEROSPHERE
BIKTARVY
bisoprolol/hctz
BOSULIF
BREQ ELLIPTA
BRETZRI AEROSPHERE
BRILINTA
budesonide nebulization
suspension
buprenorphine/naloxone
bupropion
bupropion ext-release
buspirone
butalbital/acetaminophen/
caffeine
BYDUREON [INJ]
BYETTA [INJ]

C

CABOMETYX
CALQUENCE
carbidopa/levodopa
carvedilol
cefdinir
cefuroxime axetil
celecoxib
cephalexin
CERDELGA
CEREZYME [INJ]
CETROTIDE [INJ]
CHANTIX
chlorhexidine gluconate
chlorthalidone
CIMDUO
ciprofloxacin
citalopram
clarithromycin
clindamycin hcl
clindamycin phosphate
topical
clindamycin phosphate/
benzoyl peroxide
clobetasol propionate
clomiphene citrate
clonazepam
clonidine
clopidogrel
clotrimazole/betamethasone
dipropionate
colchicine tablets
COMBIPATCH
COMBIVENT RESPIMAT
COMETRIQ
CREON

cyanocobalamin [INJ]
cyclobenzaprine

D

dapsone topical
DAYTRANA
DESCOVY
desloratadine
desvenlafaxine succinate
ext-release
dexamethasone
DEXCOM RECEIVER, SENSOR,
TRANSMITTER
dexmethylphenidate
ext-release
dextroamphetamine/
amphetamine
dextroamphetamine/
amphetamine ext-release
diazepam
diclofenac sodium
delayed-release
dicyclomine
digoxin
diltiazem ext-release
dimethyl fumarate
diphenoxylate/atropine
divalproex delayed-release
divalproex ext-release
donepezil
doxazosin
doxycycline hyclate
doxycycline monohydrate
DUAVEE
DULERA
duloxetine delayed-release
DUPIXENT [INJ]
DYANAVEL XR

E

ELIQUIS
ELOCTATE [INJ]
EMGALITY [INJ]
emtricitabine/tenofovir
disoproxil fumarate
EMVERM
enalapril
ENBREL [INJ]
ENDOMETRIN
enoxaparin [INJ]
ENSTILAR
ENTRESTO
ENTYVIO [INJ]
EPLUSA
EPIDIOLEX
epinephrine auto-injector
(by Mylan, Teva) [INJ]
EPIPEN, EPIPEN JR [INJ]
ergocalciferol
ERIVEDGE
ERLEADA
erythromycin eye ointment
ESBRIET

escitalopram
esomeprazole magnesium
delayed-release
ESPEROCT [INJ]
estradiol
estradiol patches
estradiol vaginal inserts
estradiol/norethindrone
acetate
eszopiclone
ethinyl estradiol/drospirenone
ethinyl estradiol/
drospirenone/levomefolate
ethinyl estradiol/etonogestrel
vaginal ring
ethinyl estradiol/
levonorgestrel
ethinyl estradiol/
norelgestromin patches
ethinyl estradiol/
norethindrone acetate
ethinyl estradiol/
norethindrone/iron
ethinyl estradiol/norgestimate
EUFLEXXA [INJ]
ezetimibe
ezetimibe/simvastatin

F

famotidine
FARXIGA
FASENRA [INJ]
fenofibrate
fenofibrate micronized
fenofibric acid
delayed-release
fentanyl patches
FETZIMA
FINACEA FOAM
finasteride
FLECTOR
FLOVENT DISKUS
FLOVENT HFA
fluconazole
fluocinonide
fluoxetine
fluticasone nasal spray
folic acid
FORTEO [INJ]
FRAGMIN [INJ]
FREESTYLE KITS/METERS:
FREESTYLE FREEDOM,
FREESTYLE FREEDOM LITE,
FREESTYLE INSULINX,
FREESTYLE LITE
FREESTYLE LIBRE & LIBRE 2
READER, SENSOR
FREESTYLE TEST STRIPS:
FREESTYLE,
FREESTYLE INSULINX,
FREESTYLE LITE
FULPHILA
furosemide
FYCOMPA

G

gabapentin
GAMMACORE
GELNIQUE
gemfibrozil
GENOTROPIN [INJ]
GENVOYA
GILENYA
GLASSIA [INJ]
glimepiride
glipizide
glipizide ext-release
GLUCAGEN [INJ]
GLUCAGON [INJ]
glyburide
GLYXAMBI
GONAL-F, GONAL-F RFF,
GONAL-F RFF
REDI-JECT [INJ]
GRASTEK
guanfacine ext-release
GVOKE [INJ]

H

HARVONI
HUMALOG [INJ]
HUMIRA [INJ]
HUMULIN [INJ]
hydralazine
hydrochlorothiazide
hydrocodone/acetaminophen
hydrocodone/
chlorpheniramine polistirex
ext-release
hydrocortisone topical
hydromorphone
hydroxychloroquine
hydroxyzine hcl
hydroxyzine pamoate
HYSINGLA ER

I

ibandronate
IBRANCE
ibuprofen
INBRIA
INCRUSE ELLIPTA
indomethacin
INFLECTRA [INJ]
INLYTA
irbesartan
IRESSA
isosorbide mononitrate
ext-release

J

JANUMET, JANUMET XR
JANUVIA
JARDIANCE
JIVI [INJ]
JULUCA

(continued)

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

PLEASE NOTE: Brand-name drugs may move to nonformulary status if a generic version becomes available during the year. Not all the drugs listed are covered by all prescription plans; check your benefit materials for the specific drugs covered and the copayments for your prescription plan. For specific questions about your coverage, please call the phone number printed on your member ID card.

Go to express-scripts.com/2022drugs for a full list of formulary exclusions with their covered alternatives or log on to compare drug prices. Costs for covered alternatives may vary.
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K

KANJINTI [INJ]
KESIMPTA [INJ]
ketoconazole topical
ketorolac
KITABIS PAK
KLOXXADO
KOGENATE FS [INJ]
KOVALTRY [INJ]
KYLEENA
KYNMOBI

L

labetalol
lamotrigine
lansoprazole delayed-release
latanoprost eye solution
LATUDA
LEVEMIR [INJ]
levetiracetam
levocetirizine
levofloxacin
levothyroxine sodium
LICART
lidocaine patches
LINZESS
liothyronine
LIPOFEN
lisinopril
lisinopril/hctz
LIVALO
LOKELMA
lorazepam
LORBRENA
losartan
losartan/hctz
loteprednol eye suspension
lovastatin
LUPANETA PACK [INJ]
LUPRON DEPOT
3.75 MG, 11.25 MG [INJ]
LUPRON DEPOT-PED [INJ]
LYNPARZA
LYUMJEV [INJ]

M

MAYZENT
meclizine
medroxyprogesterone
meloxicam
metaxalone
metformin
metformin ext-release
methimazole
methocarbamol
methotrexate
methylphenidate
methylphenidate ext-release
methylprednisolone
metoclopramide
metoprolol succinate
ext-release
metoprolol tartrate
metronidazole
metronidazole topical
metronidazole vaginal
minocycline
MIRENA
mirtazapine
MIRVASO
MITIGARE
mometasone
MONOVISC [INJ]
montelukast
morphine sulfate ext-release

MOVANTIK
moxifloxacin eye solution
mupirocin
MUSE
MYDAYIS
MYFEMBREE
MYRBETRIQ

N

nabumetone
NAMZARIC
naproxen, naproxen sodium
NASCOBAL
NATESTO
NAYZILAM
neomycin/polymyxin/
hydrocortisone ear solution
NEXLETOL
NEXLIZET
niacin ext-release nifedipine
ext-release NINLARO
nitrofurantoin macrocrystal
NITYR
NIVESTYM [INJ] NORDITROPIN
[INJ] nortriptyline
NOVAREL [INJ]
NOVOEIGHT [INJ]
NOVOFINE AUTOSHIELD
NEEDLES
NOVOFINE NEEDLES
NOVOTWIST NEEDLES NUBEQA
NUCALA [INJ]
NUDEXTA
nystatin
nystatin topical

O

ODACTRA
ODEFSEY
ODOMZO
OFEV
ofloxacin
olanzapine
olmesartan
olmesartan/hctz
omeprazole delayed-release
ondansetron
ondansetron orally
disintegrating tablets
ONETOUCH KITS/METERS:
ULTRA 2, ULTRAMINI,
VERIO, VERIO FLEX
ONETOUCH TEST STRIPS:
ULTRA, VERIO
ONEXTON
OPSUMIT
ORALAIR
ORIAHNN
ORILISSA
ORTHOVISC [INJ]
oseltamivir
OTEZLA
OVIDREL [INJ]
oxcarbazepine
oxybutynin ext-release
oxycodone
oxycodone/acetaminophen
OXYCONTIN
OZEMPIC [INJ]

P

PANCREAZE
pantoprazole delayed-release
paroxetine hcl
penicillin v potassium
PENTASA
PERFOROMIST
PHOSLYRA
pioglitazone
PLEGRIDY [INJ]
polymyxin/trimethoprim
eye solution
PONVORY
potassium chloride
ext-release
pramipexole
pravastatin
PRECISION XTRA METERS,
TEST STRIPS,
B-KETONE STRIPS
prednisolone acetate
eye suspension
prednisolone sodium
phosphate
prednisone
pregabalin
PREMARIN CREAM
PROCRIT [INJ]
progesterone micronized
PROLASTIN C [INJ]
promethazine
promethazine/
dextromethorphan
propranolol
propranolol ext-release

Q

QUDEXY XR
quetiapine
QUILLICHEW ER
QUILLIVANT XR
quinapril
QVAR REDHALER

R

rabeprazole delayed-release
RAGWITEK
raloxifene
ramipril
RASUVO [INJ]
REBIF [INJ]
RECTIV
RELISTOR [INJ]
RELISTOR TABLETS
REPATHA [INJ]
RESTASIS
RETACRIT [INJ]
REVLIMID
RINVOQ ER
risperidone
rizatriptan
ropinirole
rosuvastatin
ROZLYTREK
RUBRACA
RUCONEST [INJ]
RUXIENCE [INJ]
RYBELSUS

S

SAVELLA
SEGLUROMET
SEMGLEE (YFGN) [INJ]
SEREVENT DISKUS

sertraline
SEVENFACT [INJ]
sildenafil
SIMPONI 100 MG (for
Ulcerative Colitis only) [INJ]
simvastatin
SKYLA
SKYRIZI [INJ]
SOLQUA [INJ]
SOLOSEC
SOMATULINE DEPOT [INJ]
SOMAVERT [INJ]
SPIRIVA HANDIHALER
SPIRIVA RESPIMAT
spironolactone
SPRYCEL
STEGLATRO
STEGLUJAN
STELARA SC [INJ]
STIOLTO RESPIMAT
STIVARGA
STRENSIQ [INJ]
SUBLOCADE [INJ]
sulfamethoxazole/
trimethoprim
sumatriptan
SUNOSI
SUTENT
SYMBICORT
SYMFI
SYMFI LO
SYMJEPI [INJ]
SYMLINPEN [INJ]
SYMPROIC
SYMTUZA
SYNJARDY, SYNJARDY XR

T

tacrolimus topical
tadalafil
TAGRISSE
TAKHZYRO [INJ]
TALICIA
TALTZ [INJ]
TALZENNA
tamoxifen
tamsulosin ext-release
TASIGNA
TAVALISSE
TAZORAC GEL
TAZORAC 0.05% CREAM
TEGSEDI [INJ]
TEKTURN HCT
telmisartan
TEMIXYS
terazosin
terconazole vaginal
testosterone cypionate [INJ]
thyroid
timolol maleate eye solution
tizanidine
TOBI PODHALER
tobramycin eye solution
tobramycin/dexamethasone
eye suspension
topiramate
TOUJEO [INJ]
TOVIAZ
TRACLEER SUSPENSION
tramadol
travoprost eye solution
TRAZIMERA [INJ]
trazodone
TRELEGY ELLIPTA
TREMIFYA [INJ]
treprostinil [INJ]
TRESIBA [INJ]

tretinoin
triamcinolone topical
triamterene/hctz
TRIARDY XR
TRIPTODUR [INJ]
TRIUMEQ
TRULANCE
TRULICITY [INJ]
TYMLOS [INJ]

U

UCERIS FOAM
UPTRAVI

V

valacyclovir
valsartan
valsartan/hctz
VARUBI
VASCEPA
VELPHORO
venlafaxine
venlafaxine ext-release
verapamil ext-release
VERQUVO
VERZENIO
VIBERZI
VIMPAT
VIOKACE
VITRAKVI
VIZIMPRO
VOSEVI
VUMERITY
VYVANSE

W

warfarin
WEGOVY [INJ]

X

XALKORI
XARELTO
XELJANZ, XELJANZ XR
XIFAXAN
XIGDUO XR
XIIDRA
XOLAIR [INJ]
XTANDI
XULTOPHY [INJ]

Y

YONSA
YUPELRI

Z

ZARXIO [INJ]
ZEGALOGUE [INJ]
ZEJULA
ZENPEP
ZEPATIER
ZEPOSIA (for Multiple
Sclerosis only)
ZIEXTENZO [INJ]
ZIRABEV [INJ]
zolpidem
zolpidem ext-release
ZOMIG NASAL
ZTLIDO
ZUBSOLV

Go to express-scripts.com/2022drugs for a full list of formulary exclusions with their covered alternatives or log on to compare drug prices. Costs for covered alternatives may vary.

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The excluded medications shown below are not covered on the Express Scripts drug list. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

Take action to avoid paying full price. If you're currently using one of the excluded medications, please ask your doctor to consider writing you a new prescription for one of the following preferred alternatives. Additional covered alternatives may be available. Costs for covered alternatives may vary. Log on to [express-scripts.com/covered](https://www.express-scripts.com/covered) to compare drug prices. Not all the drugs listed are covered by all prescription plans; check your benefit materials for the specific drugs covered and the copayments for your plan. For specific questions about your coverage, please call the number on your member ID card.

Express Scripts manages your prescription plan for your employer, plan sponsor, health plan or benefit fund. These excluded medications do not apply to Medicare plans.

Drug Class	Excluded Medications	Preferred Alternatives
ANTIINFECTIVES		
Antibiotic Agents - Vancomycins (Oral)	FIRVANQ	vancomycin capsules, vancomycin oral solution
Antifungal Agents (Oral)	BREXAFEMME	fluconazole
	TOLSURA	itraconazole
Antivirals (Oral)	SITAVIG	acyclovir oral or cream, famciclovir, valacyclovir
Chagas Disease Agents	LAMPIT	BENZNIDAZOLE
AUTONOMIC & CENTRAL NERVOUS SYSTEM		
Alpha-2 Adrenergic Agonists (for Opioid Withdrawal)	LUCEMYRA	clonidine
Alzheimer's Agents	ADUHELM	No alternatives recommended
Anticonvulsants	APTOM	carbamazepine, oxcarbazepine, pregabalin, topiramate, VIMPAT
	FINTEPLA	DIACOMIT, EPIDIOLEX
Antimigraine Agents	ONZETRA XSAIL, ZOLMITRIPTAN NASAL SPRAY	sumatriptan nasal spray, ZOMIG NASAL
	VYEPTI	AIMOVIG, AJOVY, EMGALITY
Antiparkinsonism Agents	APOKYN	KYNMOBI
	GOCOVRI ER	amantadine capsules, amantadine tablets, amantadine oral solution
	ONGENTYS	entacapone
	XADAGO, ZELAPAR	rasagiline, selegiline
Antipsychotics (Oral)	CAPLYTA	aripiprazole, asenapine, olanzapine, quetiapine er, quetiapine fumarate, risperidone, ziprasidone, LATUDA
Antispasmodic Agents	OZOBAX	baclofen, tizanidine
Central Nervous System Non-Stimulants	QELBREE ER	atomoxetine, clonidine er, guanfacine er
Central Nervous System Stimulants	AMPHETAMINE ER SUSPENSION	dexamethylphenidate er, dextroamphetamine er, dextroamphetamine/amphetamine er, methylphenidate cd, methylphenidate er, methylphenidate la, DYANAVEL XR, MYDAYIS, QUILLICHEW ER, QUILLIVANT XR, VYVANSE
Duchenne Muscular Dystrophy (DMD) Agents	AMONDYS 45, EXONDYS 51, VILTEPSO, VYONDYS 53	No alternatives recommended
	EMFLAZA	prednisone solution, prednisone tablets
Lambert-Eaton Myasthenic Syndrome Agents	FIRDAPSE	RUZURGI
Multiple Sclerosis (Beta Interferons)	EXTAVIA	AVONEX ADMINISTRATION PACK, AVONEX PEN, BETASERON, PLEGRIDY, REBIF, REBIF REBIDOSE
Narcotic Analgesics & Combinations	APADAZ, BENZHYDROCODONE/ACETAMINOPHEN	hydrocodone/acetaminophen
	MORPHABOND ER, NUCYNTA ER, OXYCODONE ER, XTAMPZA ER	hydromorphone er, morphine sulfate er, oxycodone er, HYSINGLA ER, OXYCONTIN
	NUCYNTA	hydrocodone/acetaminophen, morphine sulfate, oxycodone, tramadol, tramadol/acetaminophen
	PRIMLEV, PROLATE SOLUTION	oxycodone/acetaminophen
	QDOLO	tramadol tablets

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
AUTONOMIC & CENTRAL NERVOUS SYSTEM <i>(continued)</i> Narcotic Antagonists	BUNAVAIL	buprenorphine/naloxone, ZUBSOLV
Sedative-Hypnotic Agents	DORAL, QUAZEPAM	estazolam, lorazepam
Selective Serotonin Reuptake Inhibitors (SSRIs) Antidepressants	PEXEVA, VIIBRYD	citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
Serotonin/Norepinephrine Reuptake Inhibitor Antidepressants	DRIZALMA SPRINKLE	desvenlafaxine er, duloxetine, venlafaxine er, FETZIMA
Transmucosal Fentanyl Analgesics	FENTANYL CITRATE BUCCAL TABLETS, FENTORA, LAZANDA, SUBSYS	fentanyl citrate lozenges
Miscellaneous Antidepressants	SPRAVATO	olanzapine/fluoxetine, bupropion, desvenlafaxine er, duloxetine, escitalopram, mirtazapine, sertraline
CARDIOVASCULAR ACE Inhibitors	EPANED	enalapril
	QBRELIS	lisinopril
Angiotensin Receptor Blockers (ARBs) and Combinations	EDARBI	candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan
	EDARBYCLOR	candesartan/hydrochlorothiazide, irbesartan/hydrochlorothiazide, losartan/hydrochlorothiazide, olmesartan/hydrochlorothiazide, telmisartan/hydrochlorothiazide, valsartan/hydrochlorothiazide, chlorthalidone plus valsartan
Anticoagulants	PRADAXA, SAVAYSA	ELIQUIS, XARELTO
Beta Blockers & Combinations	BYSTOLIC	atenolol, carvedilol, metoprolol succinate
	DUTOPROL	metoprolol tartrate/hydrochlorothiazide, metoprolol succinate er plus hydrochlorothiazide
	INDERAL XL, INNOPRAN XL	propranolol er
	KAPSPARGO SPRINKLE	metoprolol succinate
Calcium Channel Blockers	CONJUPRI	amlodipine, felodipine er, nifedipine er, nisoldipine
	KATERZIA	amlodipine
HMG & Cholesterol Inhibitor Combinations	ALTOPREV, EZALLOR SPRINKLE	atorvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, simvastatin tablets, LIVALO
PCSK9 Inhibitors	PRALUENT	REPATHA
Miscellaneous Cardiovascular Agents	CORLANOR	atenolol, bisoprolol, carvedilol, metoprolol succinate, metoprolol tartrate, propranolol
DERMATOLOGICAL Agents for Hyperhidrosis	DRYSOL	Over-the-Counter aluminum chloride containing products
Oral Agents for Acne	DORYX DR 80 MG, DORYX MPC, DOXYCYCLINE HYCLATE DR 80 MG	doxycycline hyclate, doxycycline monohydrate
	MINOCYCLINE ER CAPSULES, XIMINO	minocycline er tablets
Rosacea Agents (Oral)	DOXYCYCLINE 40 MG CAPSULES	doxycycline hyclate, doxycycline monohydrate
Rosacea Agents (Topical)	ZILXI	azelaic acid, metronidazole, sodium sulfacetamide/sulfur, FINACEA
Topical Agents for Acne	CLENIA PLUS	sodium sulfacetamide/sulfur
	CLINDAGEL, CLINDAMYCIN PHOSPHATE 1% GEL (BY OCEANSIDE)	clindamycin phosphate gel, erythromycin gel
	EPIDUO FORTE	adapalene/benzoyl peroxide
	TAZAROTENE FOAM	tazarotene cream, TAZORAC GEL
	VELTIN	clindamycin/benzoyl peroxide, clindamycin/tretinoin, erythromycin/benzoyl peroxide, ONEXTON
	WINLEVI	clindamycin phosphate gel, clindamycin/tretinoin, erythromycin gel, tretinoin, ONEXTON

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
DERMATOLOGICAL (continued) Topical Agents for Actinic Keratosis	CARAC, FLUOROURACIL 0.5% CREAM, IMIQIMOD 3.75% CREAM PUMP, KLISYRI, ZYCLARA	diclofenac 3% gel, fluorouracil 2% solution, fluorouracil 5% cream, imiquimod 5% cream
Topical Antifungals	ECOZA, LULICONAZOLE, SULCONAZOLE, XOLEGEL	ciclopirox, econazole, ketoconazole, naftifine, oxiconazole
Topical Corticosteroids	CLOCORTOLONE	betamethasone valerate, fluocinolone acetonide, triamcinolone acetonide
	IMPEKLO	betamethasone dipropionate, clobetasol, desonide, desoximetasone, diflorasone, fluocinonide, halcinonide, halobetasol, mometasone, triamcinolone
	VERDESO FOAM	desonide 0.05% cream/lotion/ointment, desoximetasone 0.25% cream/ointment
Vitamin D Analogs (Topical)	CALCIPOTRIENE FOAM, SORILUX	calcipotriene, calcitriol
Miscellaneous Topical Dermatological Agents	ALCORTIN A	hydrocortisone, mupirocin
	LIDOCAINE/TETRACAINE, PLIAGLIS	lidocaine cream, lidocaine/prilocaine cream
	TRI-LUMA	fluocinolone acetonide, hydroquinone, tretinoin
DIABETES Blood Glucose Meters & Test Strips	ASCENSIA (CONTOUR) ROCHE (ACCU-CHEK) TRIVIDIA (TRUETEST, TRUETRACK) ALL OTHER METERS & TEST STRIPS THAT ARE NOT LISTED AS PREFERRED	FREESTYLE KITS/METERS: FREESTYLE FREEDOM, FREESTYLE FREEDOM LITE, FREESTYLE INSULINX, FREESTYLE LITE FREESTYLE TEST STRIPS: FREESTYLE, FREESTYLE INSULINX, FREESTYLE LITE ONETOUCH KITS/METERS: ULTRA2, ULTRAMINI, VERIO, VERIO FLEX ONETOUCH TEST STRIPS: ULTRA, VERIO PRECISION XTRA METERS, TEST STRIPS, B-KETONE STRIPS
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors & Combinations	ALOGLIPTIN, NESINA, ONGLYZA, TRADJENTA	JANUVIA
	ALOGLIPTIN/METFORMIN, JENTADUETO, JENTADUETO XR, KAZANO, KOMBIGLYZE XR	JANUMET, JANUMET XR
	ALOGLIPTIN/PIOGLITAZONE	pioglitazone plus JANUVIA
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors/Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors Combinations	QTERN	GLYXAMBI, STEGLUJAN
Glucagon-Like Peptide-1 Agonists	ADLYXIN, VICTOZA	BYDUREON, BYETTA, OZEMPIC, TRULICITY
Insulins	ADMELOG, AFREZZA, APIDRA, FIASP, INSULIN ASPART, INSULIN ASPART PROTAMINE, INSULIN LISPRO, NOVLOG, RELION NOVLOG	HUMALOG, LYUMJEV
	INSULIN GLARGINE-YFGN, LANTUS	LEVEMIR, SEMGLEE (YFGN), TOUJEO, TRESIBA
	NOVOLIN, RELION NOVOLIN	HUMULIN
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors & Combinations	INVOKAMET, INVOKAMET XR	SEGLUROMET, SYNJARDY, SYNJARDY XR, XIGDUO XR
	INVOKANA	FARXIGA, JARDIANCE, STEGLATRO
EAR/NOSE Nasal Steroids	BECONASE AQ, OMNARIS, QNASL, ZETONNA	flunisolide, fluticasone, mometasone
Otic Fluoroquinolone Antibiotics	CIPRO HC, CIPROFLOXACIN/FLUOCINOLONE OTIC, OTOVEL	ciprofloxacin/dexamethasone otic
ENDOCRINE Cushing's Agents	ISTURISA	SIGNIFOR
Gonadotropin-Releasing Hormone (GnRH) Analogs (for Central Precocious Puberty)	FENSOLVI	LUPRON DEPOT-PED, TRIPTODUR
Growth Hormones	HUMATROPE, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SAIZENPREP, ZOMACTON	GENOTROPIN, NORDITROPIN FLEXPRO
Somatostatin Analogs	BYNFEZIA	octreotide
	MYCAPSSA, SANDOSTATIN LAR DEPOT	SOMATULINE DEPOT
	SIGNIFOR LAR	For Acromegaly: SOMATULINE DEPOT For Cushing's Disease: SIGNIFOR
Testosterone Products	AVEED	testosterone cypionate, testosterone enanthate

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
ENDOCRINE (continued) Thyroid Replacement Therapy	LEVOTHYROXINE CAPSULES, THYQUIDITY, TIROSINT, TIROSINT-SOL	levothyroxine tablets
Miscellaneous Endocrine Agents	KORLYM	ketoconazole, LYSODREN, SIGNIFOR
GASTROINTESTINAL Antidiarrheal Agents	MYTESI	diphenoxylate/atropine, loperamide
Antiemetics (Oral)	AKYNZEO CAPSULES	granisetron, ondansetron, aprepitant, VARUBI TABLETS
	ANTIVERT	meclizine
	EMEND POWDER PACKETS	aprepitant, VARUBI TABLETS
Bowel Evacuants	CLENPIQ, GOLYTELY PACKETS, OSMOPREP, PLENVU, SUPREP, SUTAB	peg-electrolyte solution (high and low volume generics)
Corticosteroids (Rectal Formulations)	CORTIFOAM	hydrocortisone enema, UCERIS FOAM
Gallstone Dissolution Agents	RELTONE	ursodiol
Gastroparesis Agents	GIMOTI	No alternatives recommended
Helicobacter Pylori Agents	HELIDAC, PYLERA	lansoprazole/amoxicillin/clarithromycin, TALICIA
Hemorrhoidal Preparations	PROCTOFOAM-HC	pramoxine/hydrocortisone
Inflammatory Bowel Agents	DIPENTUM	balsalazide disodium, mesalamine dr, mesalamine er, sulfasalazine, PENTASA
Irritable Bowel Syndrome & Chronic Constipation Agents	AMITIZA, LUBIPROSTONE	LINZESS, TRULANCE
Pancreatic Enzymes	PERTZYE	CREON, PANCREAZE, ZENPEP
Proton Pump Inhibitors	ACIPHEX SPRINKLE, DEXILANT, ESOMEPRAZOLE STRONTIUM, NEXIUM PACKETS, PRILOSEC SUSPENSION, RABEPRAZOLE DR SPRINKLE	esomeprazole magnesium, lansoprazole, omeprazole, pantoprazole, rabeprazole
HEMATOLOGICAL Antiplatelet Agents	ASPIRIN/OMEPRAZOLE DR, YOSPRALA DR	aspirin plus omeprazole, esomeprazole, lansoprazole, pantoprazole or rabeprazole
Erythropoiesis-Stimulating Agents	ARANESP, EPOGEN, MIRCERA	PROCRIT, RETACRIT
Factor Deficiency Agents & Related Products	NOVOSEVEN RT	SEVENFACT
	NUWIQ, RECOMBINATE, XYNTHA, XYNTHA SOLOFUSE	ADVATE, ADYNOVATE, AFSTYLA, ELOCTATE, ESPEROCT, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT
Granulocyte Colony Stimulating Factors	GRANIX, NEUPOGEN	NIVESTYM, ZARXIO
	NEULASTA, NYVEPRIA, UDENYCA	FULPHILA, ZIEXTENZO
Iron Replacement Agents	MONOFERRIC	sodium ferric gluconate complex, VENOFER
Sickle Cell Disease Agents	OXBRYTA	hydroxyurea, ADAKVEO, DROXIA
	SIKLOS	DROXIA
Thrombocytopenia Agents	MULPLETA	DOPTelet
HEPATITIS Hepatitis C	LEDIPASVIR/SOFOSBUVIR, MAVYRET, SOFOSBUVIR/VELPATASVIR, SOVALDI	EPCLUSA, HARVONI, VOSEVI, ZEPATIER
HIV Antiretrovirals Note: Current patients established on therapy are allowed to continue therapy.	CABENUVA	atazanavir plus lamivudine, darunavir plus lamivudine, lopinavir/ritonavir plus lamivudine, DOVATO, JULUCA, TIVICAY plus lamivudine, TIVICAY plus EDURANT
	COMPLERA	ODEFSEY
	DELSTRIGO	efavirenz/emtricitabine/tenofovir disoproxil fumarate, efavirenz/lamivudine/tenofovir disoproxil fumarate, BIKTARVY, GENVOYA, ODEFSEY, SYMFI, SYMFI LO, SYMTUZA, TRIUMEQ
	PIFELTRO	efavirenz, EDURANT
	PREZCOBIX	atazanavir, lopinavir/ritonavir, ritonavir, PREZISTA

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
HIV Antiretrovirals (<i>continued</i>) Note: Current patients established on therapy are allowed to continue therapy.	RUKOBIA ER	Coverage may be approved for the treatment of human immunodeficiency virus-1 infection in heavily treatment-experienced patients with multidrug-resistant infection.
	STRIBILD	BIKTARVY, GENVOYA
MUSCULOSKELETAL & RHEUMATOLOGY Gout Therapy	COLCHICINE CAPSULES	colchicine tablets, MITIGARE
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	DICLOFENAC 35 MG CAPSULES, INDOMETHACIN 20 MG CAPSULES, KETOROLAC NASAL SPRAY	diclofenac, etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen, piroxicam
	FENOPROFEN CAPSULES, FENORTHO, NALFON CAPSULES	fenopropfen calcium tablets, etodolac, flurbiprofen, ibuprofen, ketoprofen, meloxicam, nabumetone
	RELAFEN DS	nabumetone, etodolac, flurbiprofen, ibuprofen, ketoprofen, meloxicam, oxaprozin
	TIVORBEX	etodolac, flurbiprofen, ibuprofen, indomethacin, ketoprofen, meloxicam, nabumetone
	ZIPSOR, ZORVOLEX	diclofenac potassium, etodolac, flurbiprofen, ibuprofen, ketoprofen, meloxicam, nabumetone
Topical Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	DICLOFENAC EPOLAMINE PATCHES, PENNSAID	diclofenac sodium topical, FLECTOR PATCHES, LICART PATCHES
OBSTETRICAL & GYNECOLOGICAL Combination Patches	CLIMARA PRO	COMBIPATCH
Contraceptives	ANNOVERA, BALCOLTRA, LO LOESTRIN FE, NATAZIA, NEXTSTELLIS, TWIRLA, TYBLUME	generic oral, patch and ring contraceptives
	PHEXXI	Barrier methods of contraception, such as condoms, diaphragms, spermicides or sponges.
	SLYND	generic progestin-only oral contraceptives
Estrogen & Estrogen Modifiers for Vaginal Symptoms	ESTRING, IMVEXXY, INTRAROSA, OSPHENA	estradiol cream, estradiol vaginal inserts, PREMARIN CREAM
	FEMRING	estradiol cream, estradiol patches, estradiol tablets, estradiol vaginal inserts, PREMARIN CREAM
Estrogen/Progestin Combinations (Oral)	BIJUVA, PREMPHASE, PREMPRO	estradiol/norethindrone acetate, ethinyl estradiol/norethindrone acetate
Estrogens (Oral)	MENEST, PREMARIN TABLETS	estradiol tablets
Human Chorionic Gonadotropin‡	PREGNYL	NOVAREL, OVIDREL
Ovulatory Stimulants (Follitropins)	FOLLISTIM AQ	GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT
Prenatal Vitamins	PREGENNA, TRINAZ	generic prenatal vitamins
Topical Estrogen Agents	DIVIGEL, ELESTRIN, ESTROGEL, EVAMIST	estradiol patches
Vaginal Progestones	CRINONE 4%	medroxyprogesterone, megestrol, norethindrone, progesterone
	CRINONE 8%	ENDOMETRIN
ONCOLOGY Acute Myeloid Leukemia (AML) Agents	ONUREG	azacitidine, decitabine
Bevacizumab-Containing Agents	AVASTIN	MVASI, ZIRABEV
Breast Cancer Agents	KISQALI, KISQALI FEMARA CO-PACK, PIQRAY	IBRANCE, VERZENIO
Multiple Myeloma Agents	BLENREP, XPOVIO	DARZALEX, KYPROLIS, NINLARO, POMALYST, REVLIMID, THALOMID, VELCADE
Myelodysplastic Syndrome Agents	INQOVI	decitabine
Myelofibrosis Agents	INREBIC	JAKAFI
Non-Small Cell Lung Cancer Agents	TEPMETKO	TABRECTA
Prostate Cancer Agents	TRELSTAR	ELIGARD, FIRMAGON
Renal Cell Cancer Agents	FOTIVDA	everolimus, sunitinib malate, CABOMETYX, INLYTA, LENVIMA, NEXAVAR, VOTRIENT

‡ Please note that product placement is subject to change throughout the year based upon changes in market dynamics.

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
ONCOLOGY (continued) Rituximab-Containing Agents	RIABNI, RITUXAN, RITUXAN HYCELA, TRUXIMA	RUXIENCE
Trastuzumab-Containing Agents	HERCEPTIN, HERCEPTIN HYLECTA, HERZUMA, OGIVRI, ONTRUZANT	KANJINTI, TRAZIMERA
	PHESGO	PERJETA plus KANJINTI or TRAZIMERA
Tyrosine Kinase Inhibitors	QINLOCK	imatinib, sunitinib malate, NEXAVAR, SPRYCEL, STIVARGA, TASIGNA, VOTRIENT
	TRUSELTIQ	PEMAZYRE
OPHTHALMIC Antiglaucoma Agents (Beta-Adrenergic Blockers)	BETIMOL	timolol drops, betaxolol drops, levobunolol drops
Antiglaucoma Agents (Other)	RHOPRESSA, ROCKLATAN	betaxolol drops, bimatoprost drops, dorzolamide/timolol drops, latanoprost drops, levobunolol drops, timolol drops, travoprost drops
Antiglaucoma Agents (Ophthalmic Prostaglandins)	DURYSTA, XELPROS, ZIOPTAN	bimatoprost drops, latanoprost drops, travoprost drops
Blepharoptosis Agents	UPNEEQ	No alternatives recommended
Ophthalmic Agents - Other	CYSTADROPS	CYSTARAN
Ophthalmic Anti-Allergic	ALOCRIL, ALOMIDE, ALREX, LASTACAPT, PAZEO, ZERVIAE	azelastine drops, bepotastine drops, cromolyn drops, epinastine drops, olopatadine drops
Ophthalmic Anti-Inflammatory	FLAREX, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD	dexamethasone drops, fluorometholone drops, loteprednol drops, prednisolone drops
Ophthalmic Combinations	TOBRADEX ST, ZYLET	tobramycin/dexamethasone drops
Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	ACUVAIL, BROMSITE, NEVANAC	bromfenac drops, diclofenac drops, ketorolac drops
Ophthalmic Quinolone Antibiotics	BESIVANCE, CILOXAN OINTMENT	ciprofloxacin drops, gatifloxacin drops, levofloxacin drops, moxifloxacin drops, ofloxacin drops
OSTEOARTHRITIS Hyaluronic Acid Derivatives	DUROLANE, GEL-ONE, GELSYN-3, GENVISC 850, HYALGAN, HYMOVIS, SUPARTZ FX, SYNVIS, SYNVIS-ONE, TRILURON, TRIVISC, VISCO-3	EUFLEXXA, MONOVISC, ORTHOVISC
RENAL Nephropathic Cystinosis Agents	PROCYSBI	CYSTAGON
Nocturnal Polyuria Agents	NOCTIVA	desmopressin tablets
Overactive Bladder Agents	VESICARE LS	oxybutynin, oxybutynin er
Phosphate Binders	FOSRENOL POWDER PACKETS	lanthanum, sevelamer carbonate, sevelamer hcl, PHOSLYRA, VELPHORO
RESPIRATORY Epinephrine Auto-Injector Systems	AUVI-Q, EPINEPHRINE AUTO-INJECTOR (BY A-S MEDICATION, AMNEAL PHARMA, AVKARE)	epinephrine auto-injector (by Mylan, Teva), EPIPEN, EPIPEN JR
Immunological Agents for Asthma	CINQAIR	DUPIXENT, FASENRA, NUCALA
Long-Acting Beta Agonist Inhalers	STRIVERDI RESPIMAT	SEREVENT DISKUS
Long-Acting Muscarinic Antagonist Inhalers	TUDORZA PRESSAIR	INCRUSE ELLIPTA, SPIRIVA HANDIHALER, SPIRIVA RESPIMAT
Long-Acting Muscarinic Antagonist/ Long-Acting Beta-Agonist Combination Inhalers	DUAKLIR PRESSAIR	ANORO ELLIPTA, BEVESPI AEROSPHERE, STIOLTO RESPIMAT
Pulmonary Anti-Inflammatory Inhalers	ARMONAIR DIGIHALER, PULMICORT FLEXHALER	ARNUITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, FLOVENT DISKUS, FLOVENT HFA, QVAR REDIHALER
Pulmonary Anti-Inflammatory/ Beta-Agonist Combination Inhalers	AIRDUO DIGIHALER, AIRDUO RESPICLICK, BUDESONIDE/FORMOTEROL, FLUTICASONE/SALMETEROL (BY A-S MEDICATION, TEVA)	fluticasone/salmeterol (by Hikma, Prasco, Proficient Rx), ADVAIR HFA, BREO ELLIPTA, DULERA, SYMBICORT

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
RESPIRATORY (continued) Respiratory Agents - Other	DALIRESP	fluticasone/salmeterol (by Hikma, Prasco, Proficient Rx), ADVAIR HFA, ANORO ELLIPTA, ARNUITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, BEVESPI AEROSPHERE, BREO ELLIPTA, DULERA, FLOVENT DISKUS, FLOVENT HFA, INCRUSE ELLIPTA, PERFORMIST, QVAR REDIBALER, SEREVENT DISKUS, SPIRIVA HANDIHALER, SPIRIVA RESPIMAT, STIOLTO RESPIMAT, SYMBICORT
Short-Acting Beta ₂ -Agonist Inhalers	ALBUTEROL SULFATE HFA (BY A-S MEDICATION, PRASCO), LEVALBUTEROL HFA, PROAIR DIGIHALER, PROAIR RESPICLICK, VENTOLIN HFA, XOPENEX HFA	albuterol sulfate hfa (by Bryant Ranch, Cipla, Civica, Lupin, Par, Perrigo, Proficient Rx, Sandoz & Teva)
MISCELLANEOUS AGENTS Allergen Immunotherapy	PALFORZIA	No alternatives recommended
Gaucher Disease Agents	ELELYSO, VPRIV	CEREZYME
Glucocorticoids	ALKINDI SPRINKLE	hydrocortisone tablets
	HEMADY	dexamethasone tablets
Hereditary Angioedema	BERINERT	CINRYZE, RUCONEST
Immune Globulins	CUTAQUIG	SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
	GAMMAKED	IV: GAMMAGARD LIQUID, GAMMAGARD S-D, GAMUNEX-C SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
	HIZENTRA	SC: XEMBIFY
Immunosuppressant Agents	ENVARUS XR	tacrolimus
	LUPKYNIS	mycophenolate mofetil plus systemic corticosteroid
	OTREXUP, REDITREX	methotrexate injection, RASUVO
	XATMEP	methotrexate
Infused TNF Antagonists	AVSOLA, REMICADE, RENFLEXIS	INFLECTRA
Neuromyelitis Optica Spectrum Disorder Agents	UPLIZNA	ENSPRYNG
Osteoporosis - Bone Modifiers	EVENITY, PROLIA	alendronate, ibandronate, risedronate, zoledronic acid, FORTEO, TYMLOS
Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis	ONPATRO	TEGSEDI
Potassium Binders	VELTASSA	LOKELMA

Indication Based Management

Drug Class	Excluded Medications	Preferred Alternatives
Spinal Conditions (nr-axSpA)	COSENTYX	TALTZ, CIMZIA
Inflammatory Conditions‡ where COSENTYX is indicated	COSENTYX	TALTZ, ENBREL, HUMIRA, OTEZLA, SKYRIZI, STELARA SC, TREMFYA, XELJANZ, XELJANZ XR
Drug Class	Nonpreferred Medications	Preferred Alternatives
Inflammatory Conditions‡	All other Brand Name medications for Inflammatory Conditions are Nonpreferred. Approval may be granted following a coverage review. A trial of one or more Preferred medications is required prior to initiating therapy with a Nonpreferred medication. A formulary exception may be granted for a patient already established on therapy with a Nonpreferred medication.	Preferred: ENBREL, HUMIRA, OTEZLA, RINVOQ ER, SKYRIZI, STELARA SC, TALTZ, TREMFYA, XELJANZ, XELJANZ XR Preferred after Step through HUMIRA: ACTEMRA ULCERATIVE COLITIS ONLY Preferred after Step through HUMIRA: SIMPONI 100 MG, XELJANZ, XELJANZ XR ULCERATIVE COLITIS ONLY Step through HUMIRA and STELARA: ZEPOSIA

‡ Please note that product placement for treatment of Inflammatory Conditions in the Inflammatory Conditions Care Value (ICCV) Program are subject to change throughout the year based upon changes in market dynamics, new indications for existing products, biosimilar and new product launches.

(continued)

Excluded Medications/Products at a Glance

<p>ABILIFY^ ACANYA^ ACIPHEX^ ACIPHEX SPRINKLE ACUVAIL ADCIRCA^ ADDERALL^, ADDERALL XR^ ADLYXIN ADMELOG ADUHELM AFREZZA AGGRENOLX^ AIRDUO DIGIHALER, AIRDUO RESPICLICK AKYNZEO CAPSULES ALBUTEROL SULFATE HFA (BY A-S MEDICATION, PRASCO) ALCORTIN A ALINIA TABLETS^ ALKINDI SPRINKLE ALOCRIL ALOGIPTIN ALOGIPTIN/METFORMIN ALOGIPTIN/PIOGLITAZONE ALOMIDE ALREX ALTOPREV AMBIEN^, AMBIEN CR^ AMITIZA AMONDYS 45 AMPHETAMINE ER SUSPENSION AMPYRA^ AMRIX^ ANDROGEL^ ANNOVERA ANTIVERT ANUSOL-HC^ APADAZ APIDRA APOKYN APTOM ARANESP ARIMIDEX^ ARMONAIR DIGIHALER ASACOL HD^ ASCENSIA (CONTOUR) ASPIRIN/OMEPRAZOLE DR ATACAND^, ATACAND HCT^ ATRALIN^ ATRIPLA^ AUVI-Q AVALIDE^, AVAPRO^ AVASTIN AVEED AVODART^ AVSOLA AZOPT^ AZOR^ BALCOLTRA BARACLUDE TABLETS^ BECONASE AQ BENICAR^, BENICAR HCT^ BENZHYDROCODONE/ ACETAMINOPHEN BEPREVE^ BERINERT BESIVANCE BETIMOL BIUVA BIENREP BREXAFEMME BRISDELLE^ BROMSITE BUDESONIDE/FORMOTEROL BUNAVAIL BUPAP^ BUTRANS^ BYNFEZIA BYSTOLIC CABENUVA CALCIPOTRIENE FOAM CANASA^ CAPLYTA CARAC CELEBREX^ CELEXA^ CIALIS^ CILOXAN OINTMENT CINQAIR CIPRO HC</p>	<p>CIPROFLOXACIN/ FLUOCINOLONE OTIC CLENIA PLUS CLENPIQ CLIMARA PRO CLINDAGEL CLINDAMYCIN PHOSPHATE 1% GEL (BY OCEANSIDE) CLOCORTOLONE COLCHICINE CAPSULES COLCRYS^ COMPLERA CONCERTA^ CONJUPRI COREG^ CORLANOR CORTIFOAM COSENTYX COSOPT^, COSOPT PF^ COZAAR^, HYZAAR^ CRESTOR^ CRINONE CUPRIMINE^ CUTAQUIG CYMBALTA^ CYSTADROPS CYTOMEL^ DALIRESP DELSTRIGO DELZICOL^ DETROL^, DETROL LA^ DEXILANT DICLOFENAC 35 MG CAPSULES DICLOFENAC EPOLAMINE PATCHES DIOVAN^, DIOVAN HCT^ DIPENTUM DIVIGEL DORAL DORYX DR 50 MG^ & 200 MG^ DORYX DR 80 MG, DORYX MPC, DOXYCYCLINE HYCLATE DR 80 MG DOXYCYCLINE 40 MG CAPSULES DRIZALMA SPRINKLE DRYSOL DUAKLIR PRESSAIR DURAGESIC^ DUROLANE DURYSTA DUTOPROL ECOZA EDARBI, EDARBYCLOR EFFEXOR XR^ ELELYSO ELESTRIN ELIDEL^ EMEND CAPSULES^, TRIFOLD PACK^ EMEND POWDER PACKETS EMFLAZA ENVARUS XR EPANED EPIDUO^ EPIDUO FORTE EPINEPHRINE AUTO-INJECTOR (BY A-S MEDICATION, AMNEAL PHARMA, AVKARE) EPOGEN ESOMEPRAZOLE STRONTIUM ESTRACE CREAM^ ESTRING ESTROGEL ESTROSTEP FE^ EVAMIST EVENTY EXFORGE^, EXFORGE HCT^ EXJADE^ EXONDYS 51 EXTAVIA EZALLOR SPRINKLE FEMRING FENOPROFEN CAPSULES FENORTHO FENSOLVI FENTANYL CITRATE BUCCAL TABLETS FENTORA FIASP FINTEPLA FIRAZYR^</p>	<p>FIRDAPSE FIRVANQ FLAREX FLUOROURACIL 0.5% CREAM FLUTICASON/SALMETEROL (BY A-S MEDICATION, TEVA) FML FORTE, FML S.O.P. FOCALIN^, FOCALIN XR^ FOLLISTIM AQ FOSRENOL CHEWABLE TABLETS^ FOSRENOL POWDER PACKETS FOTIVDA GAMMAKED GANIRELIX ACETATE^ GEL-ONE GELSYN-3 GENERESS FE^ GENVISC 850 GIMOTI GLEEVEC^ GLUCOPHAGE^, GLUCOPHAGE XR^ GLUMETZA^ GOCOVRI ER GOLYTELY PACKETS GRANIX HELIDAC HEMADY HERCEPTIN, HERCEPTIN HYLECTA HERZUMA HIZENTRA HUMATROPE HYALGAN HYMOVIS IMQUIMOD 3.75% CREAM PUMP IMITREX^ IMPEKLO IMVEXX INDERAL LA^ INDERAL XL, INNOPRAN XL INDOMETHACIN 20 MG CAPSULES INQOVI INREBIC INSULIN ASPART, INSULIN ASPART PROTAMINE INSULIN GLARGINE-YFGN INSULIN LISPRO INTRAROSA INTUNIV^ INVOKAMET, INVOKAMET XR, INVOKANA ISTALOL^ ISTURISA JADENU^, JADENU SPRINKLE^ JENTADUETO, JENTADUETO XR KAPSPARGO SPRINKLE KATERZIA KAZANO KEPPRA^, KEPPRA XR^ KERYDIN^ KETOROLAC NASAL SPRAY KISQALI, KISQALI FEMARA CO-PACK KLISYRI KOMBIGLYZE XR KORLYM LAMICTAL^, LAMICTAL ODT^, LAMICTAL XR^ LAMPIT LANTUS LASTACRAFT LAZANDA LEDIPASVIR/SOFOSBUVIR LETAIRIS^ LEVALBUTEROL HFA LEVOTHYROXINE CAPSULES LEXAPRO^ LIALDA^ LIBRAX^ LIDOCAINE/TETRACAINE LIDODERM^ LIPITOR^ LO LOESTRIN FE LOCOID^, LOCOID LIPOCREAM^ LOESTRIN^, LOESTRIN FE^ LOTREL^ LOTROXEX^ LOVENOX^</p>	<p>LUBIPROSTONE LUCEMYRA LULICONAZOLE LUNESTA^ LUPKYNIS LYRICA^, LYRICA CR^ MAYVRET MAXALT^, MAXALT MLT^ MAXIDEX MENEST MESTINON^ MICARDIS^, MICARDIS HCT^ MINASTRIN 24 FE^ MINIVELLE^ MINOCYCLINE ER CAPSULES MIRCERA MIRCECET^ MONOFERRIC MORPHABOND ER MOVIPREP^ MULPLETA MYCAPSSA MYTESI NALFON CAPSULES NAMENDA XR^ NASONEX^ NATAZIA NATROBA^ NESINA NEULASTA NEUPOGEN NEURONTIN^ NEVANAC NEXIUM CAPSULES^ NEXIUM PACKETS NEXTSTELLIS NOCTIVA NORCO^ NORTHERA^ NORVASC^ NOVOLIN NOVOLIN, RELION NOVOLIN NOVOLOG, RELION NOVOLIN NOVOSEVEN RT NOXAFIL TABLETS^ NUCYNTA, NUCYNTA ER NUTROPIN AQ NUSPIN NUVARING^ NUVIGIL^ NUWIG NYVEPRIA OGIVRI OMNARIS OMNITROPE ONGLYZA ONPATRTO ONTRUZANT ONUREG ONZETRA XSAIL OSMOPREP OSPHERA OTOVEL OTREXUP OXBRYTA OXYCODONE ER OZOBAX PALFORZIA PATADAY^ PAZE0 PENNSAID PERCOCET^ PERTZYE PEXEVA PHESGO PHEXXI PIFELTRO PIQRAY PLAQUENIL^ PLAYIX^ PLENVU PLIAGLIS PRADAXA PRALUENT PRAVACHOL^ PRED MILD PREGENNA PREGNYL PREMARIN TABLETS, PREMPHASE, PREMPRO PREVACID^, PREVACID SOLUTAB^</p>	<p>PREZCOBIX PRIOLESC SUSPENSION PRIMLEV PRISTIQ^ PROAIR DIGIHALER, PROAIR RESPICLICK PROAIR HFA^ PROCTOFOAM-HC PROCYSBI PROLATE SOLUTION PROLIA PROTONIX^ PROVENTIL HFA^ PROVIGIL^ PROZAC^ PULMICORT FLEXHALER PULMICORT RESPULES^ PYLERA QBRELIS QDOLO QELBREE ER QINLOCK QNASL QTERN QUARTETTE^ QUAZEPAM RABEPRAZOLE DR SPRINKLE RANEXA^ RAPAFLO^ RECOMBINATE REDITREX RELAFEN DS RELPAK^ RELTONE REMICADE RENAGEL^ RENFLEXIS RETIN-A MICRO 0.04% & 0.1% ^ RHOPRESSA, ROCKLATAN RIABNI RITUXAN, RITUXAN HYCELA ROCHE (ACCU-CHEK) ROZEREM^ RUKOBIA ER SAFYRAL^ SAIZEN, SAIZENPREP SANDOSTATIN LAR DEPOT SAPHRIS^ SAVAYA SEASONIQUE^, LOSEASONIQUE^ SENSIPAR^ SEROQUEL^, SEROQUEL XR^ SIGNIFOR LAR SIKLOS SINGULAIR^ SITAVIG SLYND SOFOSBUVIR/VELPATASVIR SORILUX SOVALDI SPRAVATO STRATTERA^ STRIBILD STRIVERDI RESPIMAT SUBOXONE^ SUBSYS SULCONAZOLE SUPARTZ FX SUPREP SUTAB SYNTHROID^ SYNVISC, SYNVISCO-ONE TARGRETIN CAPSULES^ TAYTULLA^ TAZAROTENE FOAM TAZORAC 0.1% CREAM^ TECFIDERA^ TEKTURNA^ TEPMETKO TESTIM^ THYQUIDITY TIKOSYN^ TIMOPTIC OCUDOSE^ TIROSINT, TIROSINT-SOL TIVORBEX TOBI SOLUTION^ TOBRADEX ST TOLSURA TOPAMAX^ TOPICORT SPRAY^ TOPROL XL^</p>	<p>TRADJENTA TRANSDERM-SCOP^ TRAVATAN Z^ TRELSTAR TREMIMET^ TRI-LUMA TRIBENZOR^ TRICOR^ TRILEPTAL^ TRILURON TRINAZ TRIVIDIA (TRUETEST, TRUETRACK) TRIVISC TRUSLETIQ TRUVADA^ TRUXIMA TUDORZA PRESSAIR TWIRLA TYBLUME UDENYCA ULORIC^ UPLIZNA UPNEQ UROXATRAL^ VAGIFEM^ VALIUM^ VALTRES^ VANOS^ VELTASSA VELTIN VENTOLIN HFA VERDESO FOAM VESICARE^ VESICARE LS VIAGRA^ VICTOZA VIBRYD VILTEPSO VIMOVO^ VISCO-3 VIVELLE-DOT^ VIVLODEX^ VPRIV VYEPTI VYONDYS 53 VYTORIN^ WELCHOL^ WELLBUTRIN SR^, WELLBUTRIN XL^ WINLEVI XADAGO XALATAN^ XANAX^, XANAX XR^ XATMEP^ XELPROS XENAZINE^ XIMINO XOLEGEL XOPENEX HFA XPOVIO XTAMPZA ER XYNTHA, XYNTHA SOLOFUSE YASMIN^ YOSPRALA DR ZAVESCA^ ZEGERID^ ZELAPAR ZERVIAE ZETIA^ ZETONNA ZILXI ZIOPTAN ZIPSOR ZOCOR^ ZOHRDO ER^ ZOLMITRIPTAN NASAL SPRAY ZOLOFT^ ZOMACTON ZOMIG TABLETS^, ZOMIG ZMT^ ZONEGRAN^ ZORVOLEX ZOVIRAX OINTMENT^ ZYCLARA ZYLET ZYTIGA^</p>
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^ Multisource brand exclusion – The generic equivalent of this brand-name medication is covered under your plan. FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance. As new generic medications become available, additional multisource brand products may become excluded.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

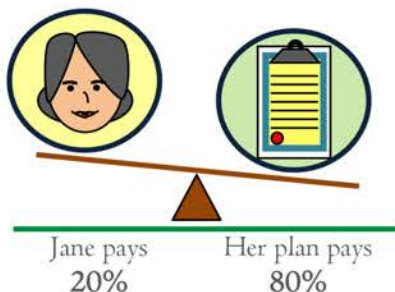
Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service.

You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

Complications of Pregnancy

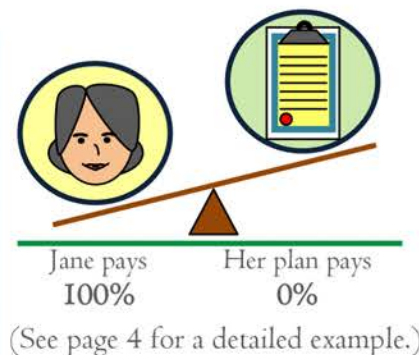
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance

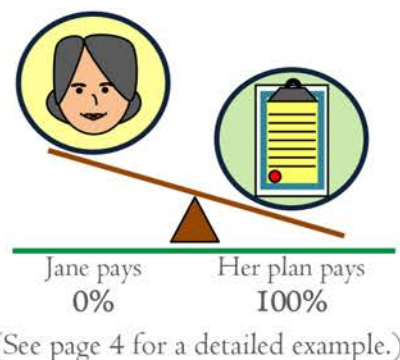
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or **plan** doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

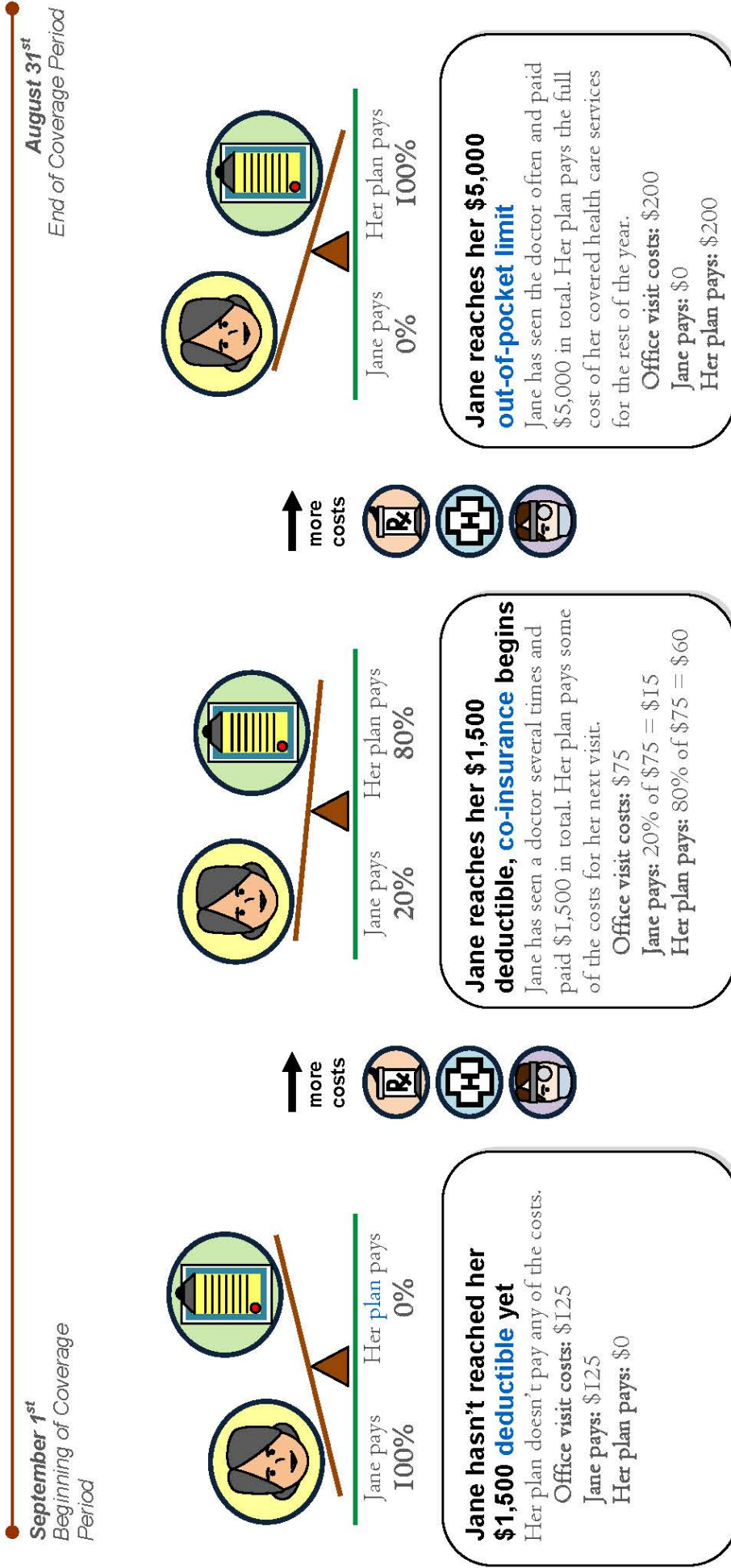
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Co-insurance: 20% Out-of-Pocket Limit: \$5,000



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