

# EMI Health Senior Products - Arizona

April 1, 2023 - March 31, 2024

- ⊕ Medigap
- 🔊 Hearing Aids



**EMI HEALTH™**

*Plans underwritten or operated by Educators Health Plans, Life, Accident, and Health*



**EMI  HEALTH™**



# Medigap Plans

---

**Medigap policies are standardized Medicare supplement insurance plans** designed to help you pay some of the healthcare costs that Original Medicare doesn't cover, such as deductibles and coinsurance. When you purchase Medigap insurance, you don't replace or cancel your Medicare Parts A and B. You still have all of your Medicare rights and protections, plus a more complete healthcare package.

Since Medigap plans are standardized, **the benefits are the same no matter which insurance company you choose.** In other words, a Plan G from one company has the same medical coverage as a Plan G from any other company. **The difference is the company itself - the quality of service and the price.**

**EMI Health provides affordable Medigap coverage and superior local service.**

# Medigap: Plan F

| Medicare Part A: Hospital Services per Benefit Period*  |  |   |                                    |           |
|---|--|---|------------------------------------|-----------|
| Service   |  | Medicare Pays   | Plan F Pays                        | You Pay   |
| <b>Hospitalization</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   | First 60 days  | All but \$1600  | \$1600 (Part A deductible)         | \$0       |
|   | Days 61 - 90   | All but \$400 a day   | \$400 a day                        | \$0       |
|   | Days 91 and later while using 60 lifetime reserve days       | All but \$800 a day   | \$800 a day                        | \$0       |
|   | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0*      |
|   | Beyond the additional 365 days                               | \$0   | \$0                                | All costs |
| <b>Skilled Nursing Facility Care</b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.  | First 20 days  | All approved amounts  | \$0                                | \$0       |
|   | Days 21-100  | All but \$200 per day   | Up to \$200 per day                | \$0       |
|   | Days 101 and later   | \$0   | \$0                                | All costs |
| <b>Blood</b>  | First 3 pints  | \$0   | 100%                               | \$0       |
|   | Additional amounts   | 100%  | \$0                                | \$0       |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.   |  | All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care | 100% of Medicare eligible expenses | \$0       |
| Medicare Part B: Medical Services per Calendar Year   |  |   |                                    |           |
| Service   |  | Medicare Pays   | Plan F Pays                        | You Pay   |
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$226 of Medicare-approved amounts*                    | \$0   | \$226 (Part B deductible)          | \$0       |
|   | Remainder of Medicare-approved amounts                       | Generally 80%   | Generally 20%                      | \$0       |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |  | \$0   | 100%                               | \$0       |



# Plan F (continued)

|                                     |  |      |      |     |
|-------------------------------------|--|------|------|-----|
| <b>Blood</b>                        | First 3 pints                            | \$0  | 100% | \$0 |
|                                     | Next \$226 of Medicare-approved amounts* | \$0  | 100% | \$0 |
|                                     | Remainder of Medicare-approved amounts   | 80%  | 20%  | \$0 |
| <b>Clinical Laboratory Services</b> | Tests for diagnostic services            | 100% | \$0  | \$0 |

## Parts A and B

| Service  |  | Medicare Pays | Plan F Pays | You Pay |
|--|--|---------------|-------------|---------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0     |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$226 of Medicare-approved amounts*                      | \$0           | 100%        | \$0     |
|  | Remainder of Medicare-approved amounts                         | 80%           | 20%         | \$0     |

## Other Benefits not covered by Medicare

| Service  |                                | Medicare Pays | Plan F Pays                                   | You Pay  |
|--|--------------------------------|---------------|---|--|
| <b>Foreign Travel</b><br>NOT COVERED BY MEDICARE -<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. | First \$250 each calendar year | \$0           | \$0   | \$250  |
|  | Remainder of charges           | \$0           | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

### \*Notes

- A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.
- Once you have been billed \$226 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**IMPORTANT MESSAGE ABOUT PLAN F** - Plan F may be purchased by those eligible for Medicare prior to January 1 2020

# Medigap: Plan G

| Medicare Part A: Hospital Services per Benefit Period*  |  |   |                                    |   |
|---|--|---|------------------------------------|---|
| Service   |  | Medicare Pays   | Plan G Pays                        | You Pay                                       |
| <b>Hospitalization</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   | First 60 days  | All but \$1600  | \$1600 (Part A deductible)         | \$0   |
|   | Days 61 - 90   | All but \$400 a day   | \$400 a day                        | \$0   |
|   | Days 91 and later while using 60 lifetime reserve days       | All but \$800 a day   | \$800 a day                        | \$0   |
|   | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0*  |
|   | Beyond the additional 365 days                               | \$0   | \$0                                | All costs                                     |
| <b>Skilled Nursing Facility Care</b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.  | First 20 days  | All approved amounts  | \$0                                | \$0   |
|   | Days 21-100  | All but \$200 per day   | Up to \$200 per day                | \$0   |
|   | Days 101 and later   | \$0   | \$0                                | All costs                                     |
| <b>Blood</b>  | First 3 pints  | \$0   | 100%                               | \$0   |
|   | Additional amounts   | 100%  | \$0                                | \$0   |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.   |  | All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care | 100%                               | \$0   |
| Medicare Part B: Medical Services per Calendar Year   |  |   |                                    |   |
| Service   |  | Medicare Pays   | Plan G Pays                        | You Pay                                       |
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$226 of Medicare-approved amounts*                    | \$0   | \$0                                | \$226 (Unless Part B deductible has been met) |
|   | Remainder of Medicare-approved amounts                       | Generally 80%   | Generally 20%                      | \$0   |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |  | \$0   | 100%                               | \$0   |



# Plan G (continued)

|                                     |  |      |           |   |
|-------------------------------------|--|------|-----------|---|
| <b>Blood</b>                        | First 3 pints                            | \$0  | All costs | \$0   |
|                                     | Next \$226 of Medicare-approved amounts* | \$0  | \$0       | \$226 (Unless Part B deductible has been met) |
|                                     | Remainder of Medicare-approved amounts   | 80%  | 20%       | \$0   |
| <b>Clinical Laboratory Services</b> | Tests for diagnostic services            | 100% | \$0       | \$0   |

## Parts A and B

| Service  |  | Medicare Pays | Plan G Pays | You Pay                                       |
|--|--|---------------|-------------|---|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0   |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$226 of Medicare-approved amounts*                      | \$0           | \$0         | \$226 (Unless Part B deductible has been met) |
|  | Remainder of Medicare-approved amounts                         | 80%           | 20%         | \$0   |

## Other Benefits not covered by Medicare

| Service   |                                | Medicare Pays | Plan G Pays                                   | You Pay  |
|---|--------------------------------|---------------|---|--|
| <b>Foreign Travel</b><br>NOT COVERED BY MEDICARE - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. | First \$250 each calendar year | \$0           | \$0   | \$250  |
|   | Remainder of charges           | \$0           | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

### \*Notes

- A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.
- Once you have been billed \$226 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

# Medigap: Rate Comparison

|     | PLAN F         | PLAN G         |
|-----|----------------|----------------|
| AGE | RATE PER MONTH | RATE PER MONTH |
| 65  | \$184          | \$131          |
| 66  | \$193          | \$137          |
| 67  | \$203          | \$144          |
| 68  | \$212          | \$151          |
| 69  | \$223          | \$158          |
| 70  | \$232          | \$164          |
| 71  | \$240          | \$169          |
| 72  | \$247          | \$175          |
| 73  | \$257          | \$181          |
| 74  | \$266          | \$187          |
| 75  | \$271          | \$192          |
| 76  | \$276          | \$196          |
| 77  | \$282          | \$200          |
| 78  | \$287          | \$204          |
| 79  | \$293          | \$208          |
| 80  | \$295          | \$210          |
| 81  | \$298          | \$212          |
| 82  | \$300          | \$216          |

|     | PLAN F         | PLAN G         |
|-----|----------------|----------------|
| AGE | RATE PER MONTH | RATE PER MONTH |
| 83  | \$302          | \$218          |
| 84  | \$306          | \$221          |
| 85  | \$307          | \$222          |
| 86  | \$308          | \$223          |
| 87  | \$310          | \$226          |
| 88  | \$311          | \$227          |
| 89  | \$312          | \$228          |
| 90  | \$313          | \$229          |
| 91  | \$316          | \$230          |
| 92  | \$317          | \$232          |
| 93  | \$318          | \$233          |
| 94  | \$319          | \$234          |
| 95  | \$320          | \$235          |
| 96  | \$322          | \$236          |
| 97  | \$323          | \$238          |
| 98  | \$324          | \$240          |
| 99  | \$325          | \$241          |

**Rates effective April 1, 2023.**





# Application Instructions



# 1. Determine Eligibility

---

You may apply for an EMI Health Medigap plan if you are a resident of Arizona, age 65 or older, and are enrolled in Medicare Parts A and B.

There are three types of application:



## Open Enrollment

If you are applying for coverage to start within the six-month period immediately following your enrollment in Medicare Part B and you are age 65 or older, this is your Open Enrollment period. During this period, you cannot be denied a Medigap policy or be charged more due to past or present health conditions.



## Guaranteed Issue

If you have lost, or are losing, other health insurance coverage you may apply for Guaranteed Issue. You will be required to provide proof that you have lost coverage within the last 63 days. If you qualify for Guaranteed Issue, you cannot be denied a Medigap policy or be charged more due to past or present health conditions.



## Other Enrollment

If you do not qualify for Open Enrollment or Guaranteed Issue, your application is subject to medical underwriting to determine whether it will be approved and, if so, at what rate.



# 2. Choose a plan

The chart below shows basic information about the different benefits that Medigap policies cover for 2023.

| Benefits  | Medicare Supplement Insurance (Medigap) Plans |      |      |      |      |      |                               |         |      |         |
|---|---|------|------|------|------|------|-------------------------------|---------|------|---------|
|   | A   | B    | C    | D    | F*   | G    | K                             | L       | M    | N       |
| Medicare Part A Coinsurance Hospital Costs up to an additional 365 days after Medicare benefits are used up | 100%  | 100% | 100% | 100% | 100% | 100% | 100%                          | 100%    | 100% | 100%    |
| Medicare Part B Coinsurance or Copayment  | 100%  | 100% | 100% | 100% | 100% | 100% | 50%                           | 75%     | 100% | 100%*** |
| Blood (First 3 Pints)   | 100%  | 100% | 100% | 100% | 100% | 100% | 50%                           | 75%     | 100% | 100%    |
| Part A Hospice Care Coinsurance or Copayment  | 100%  | 100% | 100% | 100% | 100% | 100% | 50%                           | 75%     | 100% | 100%    |
| Skilled Nursing Facility Care Coinsurance   |   |      | 100% | 100% | 100% | 100% | 50%                           | 75%     | 100% | 100%    |
| Part A Deductible   |   | 100% | 100% | 100% | 100% | 100% | 50%                           | 75%     | 50%  | 100%    |
| Part B Deductible   |   |      | 100% |      | 100% |      |                               |         |      |         |
| Part B Excess Charges   |   |      |      |      | 100% | 100% |                               |         |      |         |
| Foreign Travel Emergency (up to plan limits)  |   |      | 80%  | 80%  | 80%  | 80%  |                               |         | 80%  | 80%     |
|   |   |      |      |      |      |      | Out-of-pocket limit in 2022** |         |      |         |
|   |   |      |      |      |      |      | \$6,940                       | \$3,470 |      |         |

\* Plans F and G also have a high-deductible option which require first paying a plan deductible of \$2490 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

\*\* Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

\*\*\* Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

# 3. Complete the application

Complete (**complete answers are very important**) and sign the application and send it to EMI Health or contact your licensed insurance agent. Please review your application carefully before you sign it. Be certain that all your information has been properly recorded.





# Medigap Application

---





5101 South Commerce Drive  
Murray, Utah 84107  
801-262-7475

# EMI Health Medigap Application

Plans underwritten or operated by Educators Health Plans, Life, Accident, and Health

Please select one - this application request is for:

**Open Enrollment**

If you are applying for coverage to start within the six-month period immediately following your enrollment in Medicare Part B and you are 65 or older, this is your Open Enrollment period. During this period, you cannot be denied a Medigap policy or be charged more due to past or present health problems.

**Guaranteed**

If you have lost, or are losing, other health insurance coverage you may apply for Guaranteed Issue. You will be required to provide proof that you have lost coverage within the last 63 days. If you qualify for Guaranteed Issue, you cannot be denied a Medigap policy or be charged more due to past or present health problems.

**Other Enrollment**

If you do not fall under Open Enrollment or Guaranteed Issue, your application is subject to medical underwriting to determine whether it will be approved and, if so, at what rate.

## APPLICANT INFORMATION

Full Name (First, M.I., Last) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Birth Date (mm/dd/yyyy) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Gender (M / F) \_\_\_\_\_

Email Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_

Medicare Part A effective date (mm/dd/yyyy) \_\_\_\_\_ / 01 / \_\_\_\_\_

Medicare Part B effective date (mm/dd/yyyy) \_\_\_\_\_ / 01 / \_\_\_\_\_



## PAST AND CURRENT COVERAGE

### Medicaid Information

Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "Spend Down Program" and have not met your "Share of Cost," please answer "No" to this question.)

Yes  No

a) Will Medicaid pay your premiums for this Medigap policy?

Yes  No

b) Do you receive any benefits from Medicaid other than payments towards your Medicare Part B premium?

Yes  No

### Trial Period Information

Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)?

Yes  No

If Yes: Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End \_\_\_\_ / \_\_\_\_ / \_\_\_\_

a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medigap policy?

Yes  No

b) Was this your first time in this type of Medicare plan?

Yes  No

c) Did you voluntarily disenroll from a Medigap policy to enroll in the Medicare plan?

Yes  No

### Replacement and Other Coverage Information

Do you have another Medigap policy in force?

Yes  No

a) If Yes, with which company and what plan do you have?

\_\_\_\_\_

b) If Yes, do you intend to replace your current Medigap policy with this contract?

Yes  No

Have you had coverage under any other health insurance within the past 63 days?

Yes  No

a) If Yes, with which company and what kind of policy

\_\_\_\_\_

b) If Yes, what are your dates of coverage under the other policy? (If you are still covered under this plan, leave "End" blank.)

Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End \_\_\_\_ / \_\_\_\_ / \_\_\_\_

c) If Yes, do you intend to replace your current policy with this contact?

Yes  No



## HEALTH QUESTIONNAIRE

If you are applying during your Open Enrollment or you qualify for the Guaranteed Issue, you may skip the Health Questionnaire. If you fall under Other Enrollment, please complete the Health Questionnaire.

**Do you currently have kidney failure requiring dialysis?**

Yes

No

**Have you been admitted to a hospital as an inpatient within the last 90 days?**

Yes

No

If you answered YES to either of these questions, you are NOT eligible for these plans at this time.

Within the last three years, have you had a diagnosis, treatment, or advice relating to any of the following:

|  | Y                        | N                        |   | Y                        | N                        |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Accident, injury, or deformity                                  | <input type="checkbox"/> | <input type="checkbox"/> | 21. Kidney or bladder   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Acquired Immune Deficiency Syndrome (AIDS) or related disease   | <input type="checkbox"/> | <input type="checkbox"/> | 22. Liver disorder or hepatitis   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Alcohol or drug dependency                                      | <input type="checkbox"/> | <input type="checkbox"/> | 23. Lung problems, chronic obstructive pulmonary disease, emphysema or oxygen use | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Anemia, blood disease, or Leukemia                              | <input type="checkbox"/> | <input type="checkbox"/> | 24. Mental anxiety, emotional condition, or depression                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Arthritis or Rheumatoid Arthritis                               | <input type="checkbox"/> | <input type="checkbox"/> | 25. Muscular Disorders, Dystrophies   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Asthma or chronic bronchitis                                    | <input type="checkbox"/> | <input type="checkbox"/> | 26. Neurological disease or Parkinson's   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Back trouble (recurrent/chronic)                                | <input type="checkbox"/> | <input type="checkbox"/> | 27. Neuritis, chronic or recurrent numbness/tingling                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Cancer or tumor   | <input type="checkbox"/> | <input type="checkbox"/> | 28. Obesity (overweight)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Dementia or Alzheimer's   | <input type="checkbox"/> | <input type="checkbox"/> | 29. Prostate disorder   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Diabetes   | <input type="checkbox"/> | <input type="checkbox"/> | 30. Rectal disorder, hemorrhoids, or bleeding                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Dizziness or headaches (frequent)                              | <input type="checkbox"/> | <input type="checkbox"/> | 31. Sciatica or chronic pain  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Epilepsy or convulsions  | <input type="checkbox"/> | <input type="checkbox"/> | 32. Skin condition or disease, melanoma   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ear, nose, or throat disorders                                 | <input type="checkbox"/> | <input type="checkbox"/> | 33. Stroke  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Eye disorder, glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> | 34. Stomach disorders, frequent or chronic heartburn                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Female disorders, fibroids, or excessive or irregular bleeding | <input type="checkbox"/> | <input type="checkbox"/> | 35. Thyroid or glandular  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Gallbladder  | <input type="checkbox"/> | <input type="checkbox"/> | 36. Ulcer (stomach or duodenal)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Heart or circulatory   | <input type="checkbox"/> | <input type="checkbox"/> | 37. Varicose veins, phlebitis, or blood clots                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. High or low blood pressure or cholesterol                      | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 19. Intestines, bowel or colon                                     | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 20. Joint problems, including knee and other                       | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

# HEALTH QUESTIONNAIRE (continued)

Height (feet and inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_

Have you used any form of tobacco in the past 12 months?  Yes  No

A. Please explain below any items that you checked "Yes" on the previous page.

| Question # | Year  | Duration | Disease or Condition | Recovery complete? |
|------------|-------|----------|----------------------|--------------------|
| _____      | _____ | _____    | _____                | _____              |
| _____      | _____ | _____    | _____                | _____              |
| _____      | _____ | _____    | _____                | _____              |

B. Have you been advised to have an operation that was not performed?  Yes  No  
If Yes, please give full details, including name and address of physician

\_\_\_\_\_  
\_\_\_\_\_

C. Have you been hospitalized in the last 5 years or are you currently hospitalized or in an extended care facility?  Yes  No

If Yes, please explain below:

| Hospitalization Date | Disease, Injury, or Condition | Name of Operation |
|----------------------|-------------------------------|-------------------|
| _____                | _____                         | _____             |
| _____                | _____                         | _____             |

D. Are you planning to be hospitalized within the next 6 months?  Yes  No  
If Yes, please explain \_\_\_\_\_

\_\_\_\_\_

E. Have you taken any prescription medications within the past 12 months?  Yes  No

If Yes, please explain below:

| Medication | Medical Condition | Still taking? |
|------------|-------------------|---------------|
| _____      | _____             | _____         |
| _____      | _____             | _____         |
| _____      | _____             | _____         |

# SIGNATURE PAGE

## Please Read the Following Statements Before Signing This Application

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare health plan, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

.....  
I certify the above statements to be complete and true, to the best of my knowledge. I understand that this contract will become effective when accepted by EMI Health. I hereby authorize a licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, or other organization, or person, who has any records or knowledge of me or my health, to provide EMI Health any such information. A photographic copy of this authorization / acknowledgment will be valid as the original.

Applicant Signature \_\_\_\_\_ Date of Application \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Legal Authorized Representative Name \_\_\_\_\_ Relationship \_\_\_\_\_

Legal Authorized Representative Signature \_\_\_\_\_



# NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT (Medigap) INSURANCE OR MEDICARE ADVANTAGE

According to your application (information you have furnished), you intend to terminate the existing Medicare Supplement or Medicare Advantage and replace it with a policy to be issued by EMI Health. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement (Medigap) coverage is a wise decision, you should terminate your present Medicare Supplement (Medigap) or Medicare Advantage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY PRODUCER: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement (Medigap) policy will not duplicate your existing Medicare Supplement (Medigap) coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement (Medigap) coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits
- No change in benefits, but lower rates
- Fewer benefits and lower rates
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other (please specify) \_\_\_\_\_

Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your rates as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

\_\_\_\_\_  
\*Producer's Signature

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
EMI Health Producer Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

*\*Producer signature not required if you do not have a Producer*

# Policy Disclosures

---



## **Read your policy very carefully**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and EMI Health.



## **Right to return policy**

If you find that you are not satisfied with your policy, you may return it to EMI Health, 5101 South Commerce Drive, Murray, Utah 84107. If you send the policy back within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.



## **Policy replacement**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.



## **Premiums**

EMI Health can only raise your premium if we raise the premium for all policies like yours in Utah.



## **Notice**

This policy may not fully cover all of your medical costs. EMI Health is not connected with Medicare. This outline of coverage does not give all details of Medicare coverage. We recommend consulting the publication Medicare and You for more details.

---

# Hearing Care



## Unmatched Service

TruHearing® guides you from the first call to aftercare and beyond. Our Hearing Consultants schedule an exam, fitting, and follow-up with a licensed provider near you.



## Hearing Aids that Enhance Life

Stream your favorite music and shows with Bluetooth. Smartphone apps help you remotely adjust your hearing aids and more.



## Simply State-of-the-Art

The latest sound enhancement technology removes the sound of your speech from other sound to make your voice sound more natural. Rechargeable battery options last from breakfast to bedtime.

Call TruHearing® to learn more and schedule an appointment:

**1-877-760-1056**

TTY: 711

Hours: 8am-8pm, Monday-Friday

Check your hearing: [EMHealth-HS.TruHearing.com](https://EMHealth-HS.TruHearing.com)

## Example Savings (per aid)

| Product            | Retail Price | TruHearing Price | Savings |
|--------------------|--------------|------------------|---------|
| TruHearing Premium | \$3,205      | \$1,745          | \$1,460 |
| Signia ActivePro   | \$2,520      | \$2,095          | \$425   |
| Oticon More 3      | \$3,375      | \$1,525          | \$1,850 |
| Phonak Audéo P-R70 | \$3,100      | \$1,725          | \$1,375 |

## Your benefit also includes:

- + Risk-free 60-day trial period
- + 1 year of follow-up visits
- + 80 free batteries per non-rechargeable hearing aid
- + Full 3-year manufacturer warranty





Customer Service 801-262-7475  
[emihealth.com](http://emihealth.com)