EMI HEALTH™
MEDICAL | DENTAL | VISION

90 YEARS OF SERVICE
90 Years

APRIL 1, 2025 – MARCH 31, 2026

SENIOR PRODUCTS

Medigap | Dental | Vision | Hearing Aids

EMI HEALTH™
MEDICAL | DENTAL | VISION

CELEBRATING LIFE AT EVERY AGE

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 G

Medicare Part A: Hospital Services per Benefit Period*				
Service		**Medicare Pays**	**Plan G Pays**	**You Pay**
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
	Days 61 - 90	All but $419 a day	$419 a day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $838 a day	$838 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
Skilled Nursing Facility Care 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 $209.50 per day	Up to $209.50 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	100%	$0
	Additional amounts	100%	$0	$0
Hospice Care 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 G Pays**	**You Pay**
Medical Expenses 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 $257 of Medicare-approved amounts*	$0	$0	$257 (Unless Part B deductible has been met)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100%	$0

Medigap: Plan G (continued)

Medicare Part B: Medical Services per Calendar Year (cont).				
Service		**Medicare Pays**	**Plan G Pays**	**You Pay**
Blood	First 3 pints	$0	100%	$0
	Next $257 of Medicare-approved amounts*	$0	100%	$257 (Unless Part B deductible has been met)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B				
Service		**Medicare Pays**	**Plan G Pays**	**You Pay**
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $257 of Medicare-approved amounts*	$0	100%	$257 (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**
Foreign Travel 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	$257
	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 $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medigap Plan G: Rates (Per Month)

AGE	PLAN G
65	$164
66	$173
67	$182
68	$190
69	$201
70	$208
71	$214
72	$222
73	$230
74	$236
75	$243
76	$247
77	$252
78	$259
79	$263
80	$266
81	$269
82	$272

AGE	PLAN G
83	$276
84	$279
85	$281
86	$282
87	$285
88	$286
89	$289
90	$290
91	$291
92	$294
93	$295
94	$296
95	$297
96	$298
97	$301
98	$304
99	$305

Rates Effective April 1, 2025

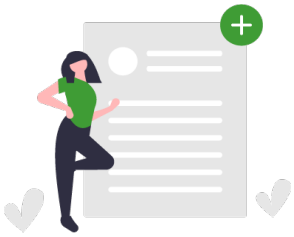
Application Instructions

STEP 1

Determine Elibility

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

There are three types of application:



Option A: 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.

Option B: 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.

Option C: 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.

STEP 2

CHOOSE PLAN

The chart below shows basic information about the different benefits that Medigap policies cover for 2025.

Medigap Benefit	PLAN A	PLAN B	PLAN C	PLAN D	PLAN F*	**PLAN G***	PLAN K	PLAN L	PLAN M	PLAN N
Medicare Part A Coinsurance Hospital Costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood (First 3 Pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance	x	x	✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible	x	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible	x	x	✓	x	✓	**x**	x	x	x	x
Part B Excess Charges	x	x	x	x	✓	✓	x	x	x	x
Foreign Travel Emergency (up to plan limits)	x	x	80%	80%	80%	**80%**	x	x	80%	80%

*Plans F & G offer a high deductible plan in some states.

**Plans K & L show how much they'll pay for approved services before you meet your out-of-pocket yearly limit and Part B deductible. After you meet them, the plan will pay 100% of your costs for approved services.

***Plan N pays 100% of the costs of Part B services, except for copayments for some office visits and some emergency room visits.

STEP 3

Complete 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.

EMI HEALTH

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 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 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 / ____

PLAN SELECTION - Choose one of the following Medigap Plans.

(The monthly premium rate can be found in the Outline of Coverage. Medigap policies are effective on the first of the month after approval.)

☐ Plan G

Requested Medigap start date (mm/dd/yyyy)_____ / 01 / _____

HOUSEHOLD DISCOUNT

A household discount may be available if two or more members reside at the same address. (The household discount only applies to Medigap policies, and is not retroactive.)

Are you requesting the Household Premium Discount? ☐ Yes ☐ No

a) If Yes, please provide the following information for the other person:

Name (First, M.I., Last) _____

DOB (mm/dd/yyyy) _____ / _____ / _____ SSN _____ — _____ — _____

Address _____

Upon verification of eligibility, both Medigap policies will qualify for the Household Premium Discount of 5% per policy (effective the 1st of the month following the date the discount is approved).

PAYMENT OPTIONS - Please select a payment option.

☐ Receive a monthly bill (direct billing)

☐ Electronic Funds Transfer (EFT) directly from your account each month. Please provide the following information and include/attach a VOIDED check.

Account Type ☐ Checking ☐ Savings

Account Holder _____ Signature _____

Routing # _____ Account # _____

By signing above, I hereby authorize EMI Health to withdraw my total monthly premium payment on or about the first day of each month, for the following month's premium, as indicated above. The authority is to remain in effect until EMI Health has received written notification from me at least 30 days prior to the next scheduled payment, or until I receive written notification of termination from EMI Health. Failed withdrawls will be subject to an additional administrative fee.

PRODUCER INFORMATION - To be completed by Producer when applicable.

I, (the producer), certify that I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions, or limitations of the contract except through written materials furnished by EMI Health. I have informed the applicant that the effective date of coverage is assigned only by EMI Health.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Producer Name _____ EMI Health Producer # _____

Producer Signature _____ Date (mm/dd/yyyy) _____ / _____ / _____

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

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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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.

Dental: Choice PPO High

Single - $49.00/month **Couple - $87.00/month**

DENTAL COVERAGE BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Plan	Senior Choice PPO (High)		
Network	**Advantage Network**	**Premier Network**	**Out-of-Network**
Type 1 - Preventive Oral Exams, Cleanings, X-Rays	100%	100%	100% up to MAC*
Type 2 - Basic Fillings	80%	80%	80% up to MAC*
Type 3 - Major Crowns, Bridges, Prosthodontics	50%	50%	50% up to MAC*
Type 4 - Orthodontics All Members (Discount)	Discount Only	Discount Only	No Coverage
Oral Surgery - (Type 2)	80%	80%	80% up to MAC*
Endodontics - (Type 3)	50%	50%	50% up to MAC*
Periodontics - (Type 3)	50%	50%	50% up to MAC*
Waiting Periods			
Type 1 - Preventive	None		
Type 2 - Basic	6 Month Waiting Period		
Type 3 - Major	12 Month Waiting Period		
Type 4 - Orthodontics	N/A		
Deductible			
Per Person	$25.00	$50.00	$50.00
Family Max	$75.00	$150.00	$150.00
Deductible Applies To	Type 2 & Type 3	Type 2 & Type 3	Type 2 & Type 3
Annual Maximum Per Person	$1,500	$1,000	
	All maximums are combined up to limits above		
Orthodontic Lifetime Maximum	N/A		
Reimbursement Schedule	Advantage Plus	Premier	Premier
Provisions / Limitations / Exclusions			
Exams (including Periodontal) and Cleanings	2 per year		
Fluoride	Not Covered		
Sealants	Not Covered		
Space Maintainers	Not Covered		
Vertical Bitewing X-Rays	Up to 4, twice per year		
Periapical X-Rays	6 per year		
Panoramix X-Ray	1 every 3 years		
Impacted Teeth	Covered in Type 2 - Basic		
Anesthesia (For the extraction of impacted teeth only)	Covered in Type 3 - Major		
Implants	Covered in Type 3 - Major		
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth		
Fillings on the same surface	1 every 18 months		

This policy is renewable or will continue in force at the Subscriber's option, as long as the Subscriber continues to pay all due premiums on a timely basis and meets the eligibility requirements as stated in the Policy. However, EMI Health may change the established premium rate, but only if the rate is changed for all policies of this form number. If the established premium rate changes, EMI Health will notify the Subscriber in writing at least 45 days before such change becomes effective.

*All Services are subject to EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the insured is responsible for all fees in excess of the Maximum Allowable Charge.

Dental: Choice PPO Low

Single - $38.00/month **Couple - $67.00/month**

DENTAL COVERAGE BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Plan	Senior Choice PPO (Low)		
Network	**Advantage Network**	**Premier Network**	**Out-of-Network**
Type 1 - Preventive Oral Exams, Cleanings, X-Rays	100%	100%	80% up to MAC*
Type 2 - Basic Fillings	80%	70%	60% up to MAC*
Type 3 - Major Crowns, Bridges, Prosthodontics	50%	50%	50% up to MAC*
Type 4 - Orthodontics All Members (Discount)	Discount Only	Discount Only	No Coverage
Oral Surgery - (Type 2)	80%	70%	60% up to MAC*
Endodontics - (Type 3)	50%	50%	50% up to MAC*
Periodontics - (Type 3)	50%	50%	50% up to MAC*
Waiting Periods			
Type 1 - Preventive	None		
Type 2 - Basic	6 Month Waiting Period		
Type 3 - Major	12 Month Waiting Period		
Type 4 - Orthodontics	N/A		
Deductible			
Per Person	$25.00	$50.00	$50.00
Family Max	$75.00	$150.00	$150.00
Deductible Applies To	Type 2 & Type 3	Type 2 & Type 3	Type 2 & Type 3
Annual Maximum Per Person	$1,250	$1,000	
	All maximums are combined up to limits above		
Orthodontic Lifetime Maximum	N/A		
Reimbursement Schedule	Advantage Plus	Premier	Premier
Provisions / Limitations / Exclusions			
Exams (including Periodontal) and Cleanings	2 per year		
Fluoride	Not Covered		
Sealants	Not Covered		
Space Maintainers	Not Covered		
Vertical Bitewing X-Rays	Up to 4, twice per year		
Periapical X-Rays	6 per year		
Panoramix X-Ray	1 every 3 years		
Impacted Teeth	Covered in Type 2 - Basic		
Anesthesia (For the extraction of impacted teeth only)	Covered in Type 3 - Major		
Implants	Not Covered		
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth		
Fillings on the same surface	1 every 18 months		

This policy is renewable or will continue in force at the Subscriber's option, as long as the Subscriber continues to pay all due premiums on a timely basis and meets the eligibility requirements as stated in the Policy. However, EMI Health may change the established premium rate, but only if the rate is changed for all policies of this form number. If the established premium rate changes, EMI Health will notify the Subscriber in writing at least 45 days before such change becomes effective.

*All Services are subject to EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the insured is responsible for all fees in excess of the Maximum Allowable Charge.

Dental: Advantage Copay

Single - $26.00/month

Couple - $46.00/month

DENTAL COVERAGE BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Plan	Senior Advantage Co-pay	
Network	**Advantage Network**	**Out-of-Network**
Type 1 - Preventive Oral Exams, Cleanings, X-Rays	100%	*See Claim Payment Schedule
Type 2 - Basic Fillings	*See Copay Schedule	*See Claim Payment Schedule
Type 3 - Major Crowns, Bridges, Prosthodontics	*See Copay Schedule	*See Claim Payment Schedule
Type 4 - Orthodontics All Members (Discount)	Discount Only	No Coverage
Oral Surgery - (Type 2)	*See Copay Schedule	*See Claim Payment Schedule
Endodontics - (Type 3)	*See Copay Schedule	*See Claim Payment Schedule
Periodontics - (Type 3)	*See Copay Schedule	*See Claim Payment Schedule
Waiting Periods		
Type 1 - Preventive	None	
Type 2 - Basic	6 Month Waiting Period	
Type 3 - Major	12 Month Waiting Period	
Type 4 - Orthodontics	N/A	
Deductible		
Per Person	$25.00	
Family Max	$75.00	
Deductible Applies To	Type 2 & Type 3	
Annual Maximum Per Person	No Maximum	
Orthodontic Lifetime Maximum	N/A	
Specialists	20% Discount	
Reimbursement Schedule	Advantage Fee Schedule	
Provisions / Limitations / Exclusions		
Exams (including Periodontal) and Cleanings	2 per year	
Fluoride	Not Covered	
Sealants	Not Covered	
Space Maintainers	Not Covered	
Vertical Bitewing X-Rays	Up to 4, twice per year	
Periapical X-Rays	6 per year	
Panoramix X-Ray	1 every 3 years	
Impacted Teeth	Covered in Type 2 - Basic	
Anesthesia (For the extraction of impacted teeth only)	Covered in Type 3 - Major	
Implants	Not Covered	
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth	
Fillings on the same surface	1 every 18 months	

This policy is renewable or will continue in force at the Subscriber's option, as long as the Subscriber continues to pay all due premiums on a timely basis and meets the eligibility requirements as stated in the Policy. However, EMI Health may change the established premium rate, but only if the rate is changed for all policies of this form number. If the established premium rate changes, EMI Health will notify the Subscriber in writing at least 45 days before such change becomes effective.

All Services are subject to EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the insured is responsible for all fees in excess of the Maximum Allowable Charge.

*Copay Schedule and Claims Payment Schedule will be mailed with EMI Health Member ID Card

Vision: VSP 10-210

Single - $9.00/month

Couple - $18.00/month

VISION COVERAGE BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL VISION EXPENSES

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Network	VSP Choice Plus	
	In-Network	Out-of-Network
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	$210 Allowance at any VSP Doctor or $110 at Costco, Sam's Club or Walmart	Up to $90
Additional Pairs of Glasses**	Up to 20% Off Retail	N/A
Elective Contact Lenses In Lieu of Frame & Lenses		
Elective contact lens fitting, evaluations, and prescription contact lenses are covered up to plan allowance. 15% discount given off contact lens fitting and evaluation services, exluding materials.	$210 Allowance	Up to $195
Frequency		
Exam, Lenses, Frame or Contacts	Every 12 Months	
Refractive Surgery		
LASIK***	Up to $500 in Savings	Not Covered

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.

EMI HEALTH

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

Utah Senior Individual Dental and Vision

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

APPLICANT INFORMATION

Full Name (First, M.I., Last) _____

Street Address _____

City _____ County _____ State _____ Zip Code _____

Phone Number ( ) _____ Email Address _____

Birth Date (mm/dd/yyyy) ____/____/____ Age _____ Gender (M/F) _____

Social Security Number ____—____—____

If you intend to cover a spouse - please complete.

Covered Spouse Full Name (First, M.I., Last) _____

Birth Date (mm/dd/yyyy) ____/____/____ Age _____ Gender (M/F) _____

Social Security Number ____—____—____

Once this policy is in place, will you have any other dental coverage? ☐ Yes ☐ No

a) If Yes, who is the subscriber/policy holder? _____

b) Name of other insurance company/dental carrier _____

DENTAL PLAN SELECTION

SENIOR CHOICE PPO - HIGH
- ☐ Single - $49.00
- ☐ Couple - $87.00

SENIOR CHOICE PPO - LOW
- ☐ Single - $38.00
- ☐ Couple - $67.00

SENIOR DENTAL ADV COPAY
- ☐ Single - $26.00
- ☐ Couple - $46.00

VISION PLAN SELECTION

VISION 10-210
- ☐ Single - $ 9.00
- ☐ Couple - $18.00

Requested Effective Date (mm/dd/yyyy) ____/____/____

I wish to enroll in the EMI Health Senior Dental and/or Vision plan(s) checked above. In signing this application, I understand that the premiums are my responsibility and that I am responsible to notify EMI Health if there are any changes in my status regarding dental coverage and also agree to remain in the plan for a minimum of one year.

PAYMENT OPTIONS - Please select a payment option.

☐ Receive a monthly bill (direct billing)

☐ Electronic Funds Transfer (EFT) directly from your account each month. Please provide the following information and include/attach a VOIDED check.

Account Type ☐ Checking ☐ Savings

Account Holder _____ Signature _____

Routing # _____ Account # _____

By signing above, I hereby authorize EMI Health to withdraw my total monthly premium payment on or about the first day of each month, for the following month's premium, as indicated above. The authority is to remain in effect until EMI Health has received written notification from me at least 30 days prior to the next scheduled payment, or until I receive written notification of termination from EMI Health. Failed withdrawls will be subject to an additional administrative fee.

PRODUCER INFORMATION - To be completed by Producer when applicable.

I, (the producer), certify that I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions, or limitations of the contract except through written materials furnished by EMI Health. I have informed the applicant that the effective date of coverage is assigned only by EMI Health.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Producer Name _____ EMI Health Producer # _____

Producer Signature _____ Date (mm/dd/yyyy) ____/____/____

ELECTION TO PARTICIPATE

THIS POLICY PROVIDES DENTAL AND VISION BENEFITS ONLY. REVIEW YOUR POLICY CAREFULLY.

I apply for coverage to which I may be entitled under the terms of the policy, including binding arbitration provisions, issued by EMI Health. The proposed coverage shall not take effect until this application has been accepted by the underwriting company. Coverage under the policy begins on the applicable effective date as stated on the face page of the policy, which will be delivered to me through the US Postal Service. I understand that I am not entitled to change my coverage elections during the policy year. I authorize EMI Health to share medical information concerning me or my family with any healthcare provider providing health benefits within the scope of the policy. I understand that any person who includes any false misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature _____ Date (mm/dd/yyyy) ____/____/____

The proposed coverage shall not take effect until this application has been accepted by EMI Health. Coverage under the Policy begins on the applicable effective date as stated on the face page of the Policy, which will be delivered to the Subscriber through the US Postal Service.

EMI HEALTH | TruHearing

1-877-760-1056 | TTY: 711

Address your hearing loss for less.

Thanks to your EMI Health plan you have access to tremendous savings through TruHearing®. Your 2024 hearing program saves you up to 60% off retail.

William is wearing a *Signia® Active Pro* hearing aid.

Example pricing per aid

Product	Retail price	TruHearing price	Savings
TruHearing Advanced	$2,720	$1,250	**$1,470**
⚡ Signia® 3AX	$2,294	$1,350	**$944**
Widex Moment® Sheer™ 110	$1,839	$795	**$1,044**
ReSound OMNIA™ 7	$3,000	$1,695	**$1,305**
Oticon® Real™ 3	$2,558	$1,450	**$1,108**
⚡ Starkey Evolv® AI 1000	$1,641	$965	**$676**
⚡ Phonak® Audéo® Lumity® L-RL 90	$3,795	$2,250	**$1,545**

⚡ Rechargeable | Listed products are smartphone-compatible[1]

Your hearing aid purchase 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

Call TruHearing to get started.

1-877-760-1056 | TTY: 711

Hours: 8am–8pm, Monday–Friday

EMI HEALTH™

90 YEARS OF SERVICE

90 Years

Senior Products 2025
EMI Health | emihealth.com | 1-800-662-5851 | cs@emihealth.com

EMI.MKTG.2025SENIORPRODUCTS2.25.1458