



Administered by Educators Mutual Insurance Association
 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.		
Alpine School District September 01, 2026 - August 31, 2027 Plan B	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
GENERAL INFORMATION	YOU PAY	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note *	\$7,500 / \$15,000	\$11,000 / \$22,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Prescription Drug Deductible). Please note ♦	\$5,000 / \$10,000	\$7,500 / \$15,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% 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	
Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical Deductible). Please note ●	\$250 / \$750	
Participating Pharmacy (up to 30 day supply)	●Generic - 25% ●Preferred - 35% ●Non-Preferred - 45%	
Non-Participating Pharmacy	Not Covered	
Mail Order (up to 90 day supply)	●Generic - 25% ●Preferred - 35% (\$250 Max) ●Non-Preferred - 45%	
Specialty Pharmacy (up to 90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	●Generic - 25% (\$150 Max) ●Preferred - 25% (\$250 Max) ●Non-Preferred - 30% (\$500 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)	\$35	♦40%
Physician Office Visits (secondary care)	\$60	♦40%
Physician Office Visits (after hours)	\$50	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦20%	♦40%
Injections (office)	Covered 100%	♦40%
Surgery (office)	Covered 100%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Anesthesiology (office)	Covered 100%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness)	\$35	♦40%
Chiropractic Therapy (20 visits per Year)	\$35	♦40%
Allergy Testing	Covered 100%	♦40%

Alpine School District September 01, 2026 - August 31, 2027 Plan B	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	\$50 per person per Year, then covered 100%	Not Covered
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦40%
Medical/Surgical Care (Outpatient)	♦20%	♦40%
Emergency Room (ER)	\$400	\$400
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦20%	♦40%
Newborn	20%	♦40%
InstaCare/Urgent Care Clinic	\$60	♦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)	♦20%	♦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	♦*20%	
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)	35%	♦40%
Medical Supplies	♦20%	♦40%
Medical Supplies (office)	Covered 100%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦40%
Hearing Aids (\$2,500 per Year)	♦20%	♦40%
Orthotic Supplies (foot inserts & arch supports)	♦20%	Not Covered
Growth Hormone	♦20%	♦40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	YOU PAY	
Inpatient Services (non-residential)	♦20%	♦40%
Residential Treatment (30 days per Year)	♦20%	♦40%
Outpatient Services	♦20%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	\$35	♦40%
ADDITIONAL BENEFITS	YOU PAY	
Adoption Indemnity Benefit	The Plan pays a maximum of \$4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment	♦20%	Not Covered
Orthognathic/Mandibular Osteotomy	♦20%	Not Covered
Total Parenteral Nutrition (TPN)	♦*50%	Not Covered
Infertility (\$5,000 per lifetime. Medications that require prior authorization will apply toward the \$5,000 lifetime infertility maximum.)	♦*50%	Not Covered
Reduction Mammoplasty	♦*50%	Not Covered
Autism Applied Behavior Analysis	♦20%	♦40%
Services designated ♦ are subject to the Prescription Drug Deductible.		
Services designated ♦ are subject to the 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	
Outside of Utah	Aetna National PPO	

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.