EMI HEALTH™

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, 2025 - August 31, 2026 Plan D QHDHP	**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)	$8,000 / $16,000	$16,000 / $32,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	$7,000 / $14,000	$13,000 / $26,000
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**	
Participating Pharmacy (up to 30 day supply)	♦Generic - 20% ♦Preferred - 30% ♦Non-Preferred - 40%	
Non-Participating Pharmacy	Not Covered	
Mail Order (up to 90 day supply)	♦Generic - 20% ♦Preferred - 30% ♦Non-Preferred - 40%	
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)	♦30%	♦50%
Physician Office Visits (secondary care)	♦30%	♦50%
Physician Office Visits (after hours)	♦30%	♦50%
Physician Visits (Inpatient)	♦30%	♦50%
Physician Visits (Outpatient)	♦30%	♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦30%	♦50%
Minor Diagnostic Test, Radiology, Lab (office)	♦30%	♦50%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦30%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦30%	♦50%
Injections (office)	♦30%	♦50%
Surgery (office)	♦30%	♦50%
Surgery (Inpatient)	♦30%	♦50%
Surgery (Outpatient)	♦30%	♦50%
Anesthesiology (office)	♦30%	♦50%
Anesthesiology (Inpatient)	♦30%	♦50%
Anesthesiology (Outpatient)	♦30%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	♦30%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦30%	♦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	♦30%	♦50%

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Allergy Treatment/Serum	♦30%	Not Covered
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦30%	♦50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦30%	♦50%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦30%	♦50%
Medical/Surgical Care (Outpatient)	♦30%	♦50%
Emergency Room (ER)	♦30%	♦30%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦30%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦30%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦30%	♦50%
Newborn	♦30%	♦50%
InstaCare/Urgent Care Clinic	♦30%	♦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)	♦30%	♦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)	♦30%	
Orthodontic Injury Treatment	♦30%	
Dental Injury Treatment	♦30%	
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)	♦30%	♦50%
Medical Supplies	♦30%	♦50%
Medical Supplies (office)	♦30%	♦50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦30%	♦50%
Hearing Aids ($2,500 per Year)	♦30%	♦50%
Orthotic Supplies (foot inserts & arch supports)	♦30%	♦50%
Growth Hormone	♦30%	♦50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦30%	♦50%
Residential Treatment (30 days per Year)	♦30%	♦50%
Outpatient Services	♦30%	♦50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦30%	♦50%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment	♦30%	Not Covered
Orthognathic/Mandibular Osteotomy	♦30%	Not Covered
Total Parenteral Nutrition (TPN)	♦30%	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	♦30%	Not Covered
Autism Applied Behavior Analysis	♦30%	♦50%

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.