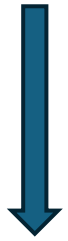
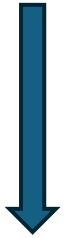
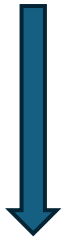
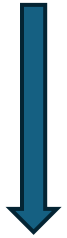
Alpine School District
2024-25 Plan Changes

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Deductible	$1500 / $3000	$1750 / $3500	$2000 / $4000	$2250 / $4500	$3000 / $6000	$5500 / $11000
Out-of-Pocket	$3000 / $6000	$4000 / $8000	$4500 / $9000	$5000 / $10000	$4000 / $8000	$7000 / $14000
Office Copay (PCP/SPC)	PCP $30, SPC $50	PCP $30, SPC $50	PCP $30, SPC $50	PCP $35, SPC $60	PCP D&C, SPC D&C	PCP D&C, SPC D&C
UC/ER	UC $50, ER $300	UC $50, ER $300	UC $50, ER $300	UC $60, ER $400	UC D&C, ER D&C	UC D&C, ER D&C
Coinsurance	100%	85%	85%	80%	80%	70%

	Plan A	Changes from Plan 2	Plan B	Changes from Plan 4	Plan C	Changes from Plan 5	Plan D	Changes from Plan 6
Deductible	$3750 / $7500	Added 2000/4000	$4250 / $8500	Added 2000/4000	$5000 / $10000	Added 2000/4000	$7000 / $14000	Added 1500/3000
Out-of-Pocket	$6000 / $12000	Added 2000/4000	$7000 / $14000	Added 2000/4000	$6000 / $12000	Added 2000/4000	$8000 / $16000	Added 1000/2000
Office Copay (PCP/SPC)	PCP $30, SPC $50	No Change	PCP $35, SPC $60	No Change	PCP D&C, SPC D&C	No Change	PCP D&C, SPC D&C	No Change
UC/ER	UC $50, ER $300	No Change	UC $60, ER $400	No Change	UC D&C, ER D&C	No Change	UC D&C, ER D&C	No Change
Coinsurance	85%	No Change	80%	No Change	80%	No Change	70%	No Change
Rx		Mail Order, Specialty, DAW1		Mail Order, Specialty, DAW1		Specialty and DAW1		Specialty and DAW1
Garner		Added a 2000/4000 HRA		Added a 2000/4000 HRA		Added a 2000/4000 HRA		Added a 1500/3000 HRA

Alpine School District

Plan Comparison

2024-25 Contract Year

Administered by Educators Mutual Insurance Association
EMI Health Customer Service 801-262-7475 or 1-800-662-5851
Self Funded Employee Medical Benefit Plan

Alpine School District	Plan A		Plan B		Plan C QHDHP	
September 01, 2024 - August 31, 2025 Care Plus	**Participating Provider Option**	**Non-Participating Provider Option**	**Participating Provider Option**	**Non-Participating Provider Option**	**Participating Provider Option**	**Non-Participating Provider Option**
Medical Deductible (Per Person/Family Per Year). Please note ♦ Benefit Accumulator: Contract Year	$3,750 / $7,500	$5,500 / $11,000	$4,250 / $8,500	$6,500 / $13,000	$5,000 / $10,000	$8,000 / $16,000
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note * Deductible is included in the Out-of-Pocket Maximum	$6,000 / $12,000	$8,000 / $16,000	$7,000 / $14,000	$10,000 / $20,000	$6,000 / $12,000	$9,500 / $19,000
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦15%	♦40%	♦20%	♦40%	♦20%	♦40%
Coinsurance	♦15%	♦40%	♦20%	♦40%	♦20%	♦40%
Physician Office Visits (primary care)	$30	♦40%	$35	♦40%	♦20%	♦40%
Physician Office Visits (specialist care)	$50	♦40%	$60	♦40%	♦20%	♦40%
Eligible Preventive Services	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Urgent Care Clinic	$50	♦40%	$60	♦40%	♦20%	♦40%
Emergency Room (ER)	$300	$300	$400	$400	♦20%	♦20%
Prescription Drugs	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**
Participating and Mail Order Pharmacies	Generic - 25%	Generic - 25%	●Generic - 25%	●Generic - 25%	♦Generic - 20%	♦Generic - 20%
	Preferred - 35%	Preferred - 35% ($250 Max)	●Preferred - 35%	●Preferred - 35% ($250 Max)	♦Preferred - 30%	♦Preferred - 30%
	Non-Preferred - 45%	Non-Preferred - 45%	●Non-Preferred - 45%	●Non-Preferred - 45%	♦Non-Preferred - 40%	♦Non-Preferred - 40%
Prescription Drug Deductible	None		$250 / $750		Medical Deductible Applies to Rx	
Specialty Pharmacy	Generic - 25% ($150 Max)		●Generic - 25% ($150 Max)		♦Generic - 25% ($150 Max)	
	Preferred - 25% ($250 Max)		●Preferred - 25% ($250 Max)		♦Preferred - 25% ($250 Max)	
	Non-Preferred - 30% ($500 Max)		●Non-Preferred - 30% ($500 Max)		♦Non-Preferred - 30% ($500 Max)	
Specialty Pharmacy SaveOnSP Program	Must enroll to receive: *$0 Copay		Must enroll to receive: *$0 Copay		Must enroll to receive: *$0 Copay	

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.

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 the applicable Out-of-Pocket Maximum.

Alpine School District

Plan Comparison

2024-25 Contract Year

Administered by Educators Mutual Insurance Association

EMI Health Customer Service 801-262-7475 or 1-800-662-5851

Self Funded Employee Medical Benefit Plan

Alpine School District	Plan A		Plan B		Plan C QHDHP		Plan D QHDHP	
September 01, 2024 - August 31, 2025 Care Plus	**Participating Provider Option**	**Non-Participating Provider Option**	**Participating Provider Option**	**Non-Participating Provider Option**	**Participating Provider Option**	**Non-Participating Provider Option**	**Participating Provider Option**	**Non-Participating Provider Option**
Medical Deductible (Per Person/Family Per Year). Please note ♦ Benefit Accumulator: Contract Year	$3,750 / $7,500	$5,500 / $11,000	$4,250 / $8,500	$6,500 / $13,000	$5,000 / $10,000	$8,000 / $16,000	$7,000 / $14,000	$13,000 / $26,000
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note * Deductible is included in the Out-of-Pocket Maximum	$6,000 / $12,000	$8,000 / $16,000	$7,000 / $14,000	$10,000 / $20,000	$6,000 / $12,000	$9,500 / $19,000	$8,000 / $16,000	$16,000 / $32,000
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦15%	♦40%	♦20%	♦40%	♦20%	♦40%	♦30%	♦50%
Coinsurance	♦15%	♦40%	♦20%	♦40%	♦20%	♦40%	♦30%	♦50%
Physician Office Visits (primary care)	$30	♦40%	$35	♦40%	♦20%	♦40%	♦30%	♦50%
Physician Office Visits (specialist care)	$50	♦40%	$60	♦40%	♦20%	♦40%	♦30%	♦50%
Eligible Preventive Services	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Urgent Care Clinic	$50	♦40%	$60	♦40%	♦20%	♦40%	♦30%	♦50%
Emergency Room (ER)	$300	$300	$400	$400	♦20%	♦20%	♦30%	♦30%
Prescription Drugs	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**
Participating and Mail Order Pharmacies	Generic - 25%	Generic - 25%	●Generic - 25%	●Generic - 25%	♦Generic - 20%	♦Generic - 20%	♦Generic - 20%	♦Generic - 20%
	Preferred - 35%	Preferred - 35% ($250 Max)	●Preferred - 35%	●Preferred - 35% ($250 Max)	♦Preferred - 30%	♦Preferred - 30%	♦Preferred - 30%	♦Preferred - 30%
	Non-Preferred - 45%	Non-Preferred - 45%	●Non-Preferred - 45%	●Non-Preferred - 45%	♦Non-Preferred - 40%	♦Non-Preferred - 40%	♦Non-Preferred - 40%	♦Non-Preferred - 40%
Prescription Drug Deductible	None		$250 / $750		Medical Deductible Applies to Rx		Medical Deductible Applies to Rx	
Specialty Pharmacy	Generic - 25% ($150 Max)		●Generic - 25% ($150 Max)		♦Generic - 25% ($150 Max)		♦Generic - 25% ($150 Max)	
	Preferred - 25% ($250 Max)		●Preferred - 25% ($250 Max)		♦Preferred - 25% ($250 Max)		♦Preferred - 25% ($250 Max)	
	Non-Preferred - 30% ($500 Max)		●Non-Preferred - 30% ($500 Max)		♦Non-Preferred - 30% ($500 Max)		♦Non-Preferred - 30% ($500 Max)	
Specialty Pharmacy SaveOnSP Program	Must enroll to receive: *$0 Copay		Must enroll to receive: *$0 Copay		Must enroll to receive: *$0 Copay		Must enroll to receive: *$0 Copay	

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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 the applicable Out-of-Pocket Maximum.

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, 2024 - August 31, 2025 Plan A	**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 *	$6,000 / $12,000	$8,000 / $16,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	$3,750 / $7,500	$5,500 / $11,000
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 - 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)	$30	♦40%
Physician Office Visits (secondary care)	$50	♦40%
Physician Office Visits (after hours)	$40	♦40%
Physician Visits (Inpatient)	♦15%	♦40%
Physician Visits (Outpatient)	♦15%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦15%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦15%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦15%	♦40%
Injections (office)	Covered 100%	♦40%
Surgery (office)	Covered 100%	♦40%
Surgery (Inpatient)	♦15%	♦40%
Surgery (Outpatient)	♦15%	♦40%
Anesthesiology (office)	Covered 100%	♦40%
Anesthesiology (Inpatient)	♦15%	♦40%
Anesthesiology (Outpatient)	♦15%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦15%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦15%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness)	$30	♦40%
Chiropractic Therapy (20 visits per Year)	$30	♦40%

Alpine School District September 01, 2024 - August 31, 2025 Plan A	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Testing	Covered 100%	♦40%
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)	♦15%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦15%	♦40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦15%	♦40%
Medical/Surgical Care (Outpatient)	♦15%	♦40%
Emergency Room (ER)	$300	$300
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦15%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦15%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦15%	♦40%
Newborn	15%	40%
InstaCare/Urgent Care Clinic	$50	♦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)	♦15%	♦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	♦*15%	
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)	40%	♦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)	♦15%	♦40%
Residential Treatment (30 days per Year)	♦15%	♦40%
Outpatient Services	♦15%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	$30	♦40%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN)	♦*50%	Not Covered
Infertility ($5,000 per lifetime. Medications that require prior authorization will apply toward the $5000 lifetime infertility maximum.)	♦*50%	Not Covered
Reduction Mammoplasty	♦*50%	Not Covered
Autism Applied Behavior Analysis	♦15%	♦40%

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

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Alpine School District September 01, 2024 - August 31, 2025 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 *	$7,000 / $14,000	$10,000 / $20,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Prescription Drug Deductible). Please note ♦	$4,250 / $8,500	$6,500 / $13,000
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%

Alpine School District September 01, 2024 - August 31, 2025 Plan B	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Testing	Covered 100%	♦40%
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)	30%	♦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	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN)	♦*50%	Not Covered
Infertility ($5,000 per lifetime. Medications that require prior authorization will apply toward the $5000 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

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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, 2024 - August 31, 2025 Plan C 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)	$6,000 / $12,000	$9,500 / $19,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	$5,000 / $10,000	$8,000 / $16,000
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)	♦20%	♦40%
Physician Office Visits (secondary care)	♦20%	♦40%
Physician Office Visits (after hours)	♦20%	♦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)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦20%	♦40%
Injections (office)	♦20%	♦40%
Surgery (office)	♦20%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Anesthesiology (office)	♦20%	♦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)	♦20%	♦40%
Chiropractic Therapy (20 visits per Year)	♦20%	♦40%

Alpine School District September 01, 2024 - August 31, 2025 Plan C QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Testing	♦20%	♦40%
Allergy Treatment/Serum	♦20%	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)	♦20%	♦20%
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	♦20%	♦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)	♦30%	♦40%
Medical Supplies	♦20%	♦40%
Medical Supplies (office)	♦20%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦40%
Hearing Aids ($2,500 per Year)	♦20%	♦40%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦40%
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	♦20%	♦40%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN)	♦20%	Not Covered
Infertility ($5,000 per lifetime. Medications that require prior authorization will apply toward the $5000 lifetime infertility maximum.)	♦*50%	Not Covered
Reduction Mammoplasty	♦20%	Not Covered
Autism Applied Behavior Analysis	♦20%	♦40%

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

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Alpine School District September 01, 2024 - August 31, 2025 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%

Alpine School District September 01, 2024 - August 31, 2025 Plan D QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Testing	♦30%	♦50%
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	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN)	♦30%	Not Covered
Infertility ($5,000 per lifetime. Medications that require prior authorization will apply toward the $5000 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.

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