Administered by EMI Health

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.

Colorado River Union High School District #2 July 01, 2023 - June 30, 2024 Option 1	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Calendar Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note *	$4,500 / $9,000	$10,000 / $20,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	$500 / $1,500	$1,000 / $3,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	$500 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 (30 day supply)	Generic - $10 Preferred - 30% ($35 Max) Non-Preferred - 50% ($75 Max)	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	Generic - $25 Preferred - $50 Non-Preferred - $90	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	25% ($250 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%	♦50%
Physician Office Visits (secondary care)	♦20%	♦50%
Physician Office Visits (after hours)	Covered 100%	♦50%
Physician Visits (Inpatient)	♦20%	♦50%
Physician Visits (Outpatient)	♦20%	♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	Covered 100%	♦50%
Injections (office)	Covered 100%	♦50%
Surgery (office)	Covered 100%	♦50%
Surgery (Inpatient)	♦20%	♦50%
Surgery (Outpatient)	♦20%	♦50%
Anesthesiology (office)	Covered 100%	♦50%
Anesthesiology (Inpatient)	♦20%	♦50%
Anesthesiology (Outpatient)	♦20%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 60 visits per Year per injury/illness)	Covered 100%	♦50%
Chiropractic Therapy (60 visits per Year)	Covered 100%	♦50%
Allergy Testing	20%	♦50%

Colorado River Union High School District #2 July 01, 2023 - June 30, 2024 Option 1	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	20%	♦50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦50%
Skilled Nursing Facility (60 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦50%
Medical/Surgical Care (Outpatient)	♦20%	♦50%
Emergency Room (ER)	♦20%	♦20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	Covered 100%	♦50%
Newborn	20%	50%
Urgent Care Clinic	♦20%	♦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)	♦20%	♦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)	♦20%	
Orthodontic Injury Treatment	♦*50%	
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)	$50	♦50%
Medical Supplies	♦20%	♦50%
Medical Supplies (office)	Covered 100%	♦50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦50%
Hearing Aids ($2,500 per Year)	♦20%	♦50%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦50%
Growth Hormone	♦20%	♦50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦50%
Residential Treatment (60 days per Year)	♦20%	♦50%
Outpatient Services	♦20%	♦50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦20%	♦50%
ADDITIONAL BENEFITS	**YOU PAY**	
TMJ Syndrome diagnosis & non-surgical treatment	♦*50%	Not Covered
Orthognathic/Mandibular Osteotomy	♦*50%	Not Covered
Total Parenteral Nutrition (TPN)	♦*50%	Not Covered
Initial assessment and diagnosis of Primary Infertility	♦*50%	Not Covered
Reduction Mammoplasty	♦*50%	Not Covered
Autism Applied Behavior Analysis	♦20%	♦50%

Services designated ♦ are subject to first dollar 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
Arizona	Blue Cross® Blue Shield® of Arizona
Outside of Utah and Arizona	First Health

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

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.

Administered by EMI Health

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

Self Funded Employee Medical Benefit Plan

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Colorado River Union High School District #2 July 01, 2023 - June 30, 2024 Option 2	Care Plus Participating Provider Option	 Non-Participating Provider Option
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Calendar Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note *	$5,000 / $10,000	$15,000 / $30,000
Medical Deductible (Per Person/Family Per Year). Please note ♦	$750 / $2,250	$1,500 / $4,500
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	$500 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 (30 day supply)	Generic - $10 Preferred - 30% ($35 Max) Non-Preferred - 50% ($75 Max)	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	Generic - $25 Preferred - $50 Non-Preferred - $90	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	25% ($250 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	♦50%
Physician Office Visits (secondary care)	$40	♦50%
Physician Office Visits (after hours)	$40	♦50%
Physician Visits (Inpatient)	♦20%	♦50%
Physician Visits (Outpatient)	♦20%	♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦50%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	Covered 100%	♦50%
Injections (office)	Covered 100%	♦50%
Surgery (office)	Covered 100%	♦50%
Surgery (Inpatient)	♦20%	♦50%
Surgery (Outpatient)	♦20%	♦50%
Anesthesiology (office)	Covered 100%	♦50%
Anesthesiology (Inpatient)	♦20%	♦50%
Anesthesiology (Outpatient)	♦20%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 60 visits per Year per injury/illness)	$20	♦50%
Chiropractic Therapy (60 visits per Year)	$20	♦50%
Allergy Testing	20%	♦50%

Colorado River Union High School District #2 July 01, 2023 - June 30, 2024 Option 2	Care Plus Participating Provider Option	 Non-Participating Provider Option
Allergy Treatment/Serum	20%	♦50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦50%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦50%
Skilled Nursing Facility (60 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦50%
Medical/Surgical Care (Outpatient)	♦20%	♦50%
Emergency Room (ER)	♦20%	♦20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	Covered 100%	♦50%
Newborn	20%	50%
Urgent Care Clinic	$40	♦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)	♦20%	♦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)	♦20%	
Orthodontic Injury Treatment	♦*50%	
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)	$50	♦50%
Medical Supplies	♦20%	♦50%
Medical Supplies (office)	Covered 100%	♦50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦50%
Hearing Aids ($2,500 per Year)	♦20%	♦50%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦50%
Growth Hormone	♦20%	♦50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦50%
Residential Treatment (60 days per Year)	♦20%	♦50%
Outpatient Services	♦20%	♦50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	$20	♦50%
ADDITIONAL BENEFITS	**YOU PAY**	
TMJ Syndrome diagnosis & non-surgical treatment	♦*50%	Not Covered
Orthognathic/Mandibular Osteotomy	♦*50%	Not Covered
Total Parenteral Nutrition (TPN)	♦*50%	Not Covered
Initial assessment and diagnosis of Primary Infertility	♦*50%	Not Covered
Reduction Mammoplasty	♦*50%	Not Covered
Autism Applied Behavior Analysis	♦20%	♦50%

Services designated ♦ are subject to first dollar 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
Arizona	Blue Cross® Blue Shield® of Arizona
Outside of Utah and Arizona	First Health

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

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Self Funded Employee Medical Benefit Plan

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Colorado River Union High School District #2 July 01, 2023 - June 30, 2024 Option 3 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Calendar Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Single/Family Per Year)	$3,500 / $6,550	$15,000 / $30,000
Medical Deductible (Per Single/Family Per Year). Please note ♦	$1,500 / $3,000	$3,000 / $6,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	$500 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 (30 day supply)	♦Generic - $10 ♦Preferred - 30% ($35 Max) ♦Non-Preferred - 50% ($75 Max)	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	♦Generic - $25 ♦Preferred - $50 ♦Non-Preferred - $90	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	♦25% ($250 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%	♦50%
Physician Office Visits (secondary care)	♦20%	♦50%
Physician Office Visits (after hours)	♦20%	♦50%
Physician Visits (Inpatient)	♦20%	♦50%
Physician Visits (Outpatient)	♦20%	♦50%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (office)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦50%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦20%	♦50%
Injections (office)	♦20%	♦50%
Surgery (office)	♦20%	♦50%
Surgery (Inpatient)	♦20%	♦50%
Surgery (Outpatient)	♦20%	♦50%
Anesthesiology (office)	♦20%	♦50%
Anesthesiology (Inpatient)	♦20%	♦50%
Anesthesiology (Outpatient)	♦20%	♦50%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦50%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦50%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 60 visits per Year per injury/illness)	♦20%	♦50%
Chiropractic Therapy (60 visits per Year)	♦20%	♦50%
Allergy Testing	♦20%	♦50%
Allergy Treatment/Serum	♦20%	♦50%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦50%

Colorado River Union High School District #2 July 01, 2023 - June 30, 2024 Option 3 QHDHP	Care Plus Participating Provider Option	 Non-Participating Provider Option
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦50%
Skilled Nursing Facility (60 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦50%
Medical/Surgical Care (Outpatient)	♦20%	♦50%
Emergency Room (ER)	♦20%	♦20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦50%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦50%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦20%	♦50%
Newborn	♦20%	♦50%
Urgent Care Clinic	♦20%	♦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)	♦20%	♦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)	♦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)	♦$50	♦50%
Medical Supplies	♦20%	♦50%
Medical Supplies (office)	♦20%	♦50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦50%
Hearing Aids ($2,500 per Year)	♦20%	♦50%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦50%
Growth Hormone	♦20%	♦50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦50%
Residential Treatment (60 days per Year)	♦20%	♦50%
Outpatient Services	♦20%	♦50%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦20%	♦50%
ADDITIONAL BENEFITS	**YOU PAY**	
TMJ Syndrome diagnosis & non-surgical treatment	♦20%	Not Covered
Orthognathic/Mandibular Osteotomy	♦20%	Not Covered
Total Parenteral Nutrition (TPN)	♦20%	Not Covered
Initial assessment and diagnosis of Primary Infertility	♦20%	Not Covered
Reduction Mammoplasty	♦20%	Not Covered
Autism Applied Behavior Analysis	♦20%	♦50%

Services designated ♦ are subject to first dollar 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.

Single/Family note: The Single Deductible and Out-of-Pocket Maximum amounts apply only to those Covered Persons with single coverage. Covered Persons with family (two-party or more) coverage, must meet the Family Deductible and Out-of-Pocket Maximum amounts, either individually or accumulatively as a family.

PROVIDER NETWORK	
Utah	EMI Health Care Plus
Arizona	Blue Cross® Blue Shield® of Arizona
Outside of Utah and Arizona	First Health

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