Alpine School District

Educators Customer Service 262-7475 or 1-800-662-5851

Self-funded Employee Medical Benefit Plan - Administered by Educators Mutual Insurance Association of Utah

All services are subject to Educators Table of Allowances. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Table of Allowances.

Alpine School District #16 575 North 100 East, American Fork, Utah 84003 801-610-8520	Educators Care Plus	
September 1, 2010 - August 31, 2011 Care Plus	Participating Provider Option	Non-Participating Provider Option
GENERAL INFORMATION	YOU PAY	
Lifetime Maximum Benefit	$1,000,000	
Preexisting Condition Window Period	6 months prior	
Preexisting Condition Waiting Period	First 8 months of coverage / 18 months Late Enrollees	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Coinsurance Maximum (Per Person/Family Per Plan Year)	$1,250 / $2,500	$1,250 / $2,500
First Dollar Deductible (Per Person/Family Per Plan Year)	*$200 / *$400	*$400 / *$800
Non-Preauthorization Patient Penalty	Not applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not applicable
Non-Precertification EAP Penalty	Benefits Denied	
PRESCRIPTION DRUG BENEFITS	YOU PAY	
Participating Pharmacy - Note: Prescriptions for which you can not receive a 90 day fill may be purchased through mail order in three 30 day fills for a total copay of $30.	1st fill - *25% Generic / *35% Preferred / *45% Non-Preferred 2nd fill and thereafter - *30% Generic / *40% Preferred / *50% Non-Preferred	
Significant Medication (during first 12 months after FDA approval)	*50%	
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	
Non-participating Pharmacy	Not Covered	
Mail Order (90 day supply) - Note: Restricted drugs that cannot be mailed may be purchased from a participating pharmacy for a $18 copay per 30-day supply.	*$20 Generic *$30 Preferred *$30 Non-Preferred	
DENTAL BENEFITS	YOU PAY	
Impacted Teeth/Cysts/Tumors	♦ Covered 100%	♦20%
HOSPITAL/FACILITY BENEFITS (Physician and Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦ $200	♦ 20%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦ Covered 100%	♦ 20%
Skilled Nursing Facility (60 days per Plan year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦ Covered 100%	♦ 20%
Medical/Surgical Care (Outpatient)	♦ $75	♦ 20%
Emergency Room (ER)	$150	♦ 20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦ $75	♦ 20%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦ Covered 100%	♦ 20%
Minor Diagnostic Test, X-ray, Lab (Outpatient including ER)	♦ Covered 100%	♦ 20%
Newborn	Covered 100%	♦ 20%
InstaCare Clinic	$35	♦ 20%
Pre-Admission Testing	♦ Covered 100%	♦ 20%
REHABILITATION THERAPY BENEFIT	YOU PAY	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (1 visit per day, 40 visits per Plan year)	♦ Covered 100%	♦ 20%
ACCIDENT AND LIFE THREATENING CONDITION	YOU PAY	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit subject to the Table of Allowance
Ambulance Land/Air (Accident & Life-threatening)	♦ 20%	
Orthodontic Injury Treatment	♦ Covered 100%	
Dental Injury Treatment	♦ 20%	
PHYSICIAN & PROFESSIONAL SERVICES	YOU PAY	
Physician Office Visits (primary care)	$25	♦ 20%
Physician Office Visits (secondary care)	$40	♦ 20%
Physician Office Visits (after hours)	$35	♦ 20%
Physician Visits (Inpatient)	♦ Covered 100%	♦ 20%
Physician Visits (Outpatient including ER)	♦ Covered 100%	♦ 20%
Minor Diagnostic Test, X-ray, Lab (office)	Covered 100%	♦ 20%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦ Covered 100%	♦ 20%
Minor Diagnostic Test, X-ray, Lab (Outpatient including ER)	♦ Covered 100%	♦ 20%

Services designated * do not accumulate toward your Coinsurance Maximum.

Services designated ♦ are subject to first dollar Deductible.

September 1, 2010 - August 31, 2011 Care Plus	Participating Provider Option	Non-Participating Provider Option
Radiology/Pathology (office)	Covered 100%	♦ 20%
Radiology/Pathology (Inpatient)	♦ Covered 100%	♦ 20%
Radiology/Pathology (Outpatient including ER)	♦ Covered 100%	♦ 20%
Injections (office)	Covered 100%	♦ 20%
Surgery (office)	Covered 100%	♦ 20%
Surgery (Inpatient)	♦ Covered 100%	♦ 20%
Surgery (Outpatient including ER)	♦ Covered 100%	♦ 20%
Anesthesiology (office)	Covered 100%	♦ 20%
Anesthesiology (Inpatient)	♦ Covered 100%	♦ 20%
Anesthesiology (Outpatient including ER)	♦ Covered 100%	♦ 20%
Routine Prenatal & Delivery (Dependent maternity included)	♦ Covered 100%	♦ 20%
Home Health Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦ Covered 100%	♦ 20%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary) ($1,500 per Plan year)	$25	♦ 20%
Chiropractic Therapy (20 visits per Plan year)	30% (CHP)	30%
Allergy Testing	Covered 100%	♦ 20%
Allergy Treatment/Serum	$50 per person per Year, then covered 100%	Not Covered
Chemotherapy / Radiation Therapy	♦ Covered 100%	♦ 20%
PREVENTIVE SERVICES	YOU PAY	
Routine Physical Exam (1 visit per Plan year)	$25	Not Covered
Routine Gynecological Exam (1 visit per Plan year)	$25	Not Covered
Family History Exam	Not Covered	Not Covered
Routine Pap Smear & Mammogram (1 per Plan year)	Covered 100%	Not Covered
Routine Well-Baby Exams	$25	Not Covered
Covered Child Immunizations (to 19th birthday)	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Plan year)	$25	Not Covered
Routine Hearing Exam (1 visit per Plan year)	$25	Not Covered
TRANSPLANT BENEFIT	YOU PAY	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY	
Medical Supplies	♦ 20%	♦ 20%
Medical Supplies (office)	Covered 100%	♦ 20%
Durable Medical Equipment	♦ 20%	♦ 20%
Orthotic Supplies	♦ 20%	Not Covered
Growth Hormone	♦ 20%	♦ 20%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT Precertification required from EAP or benefits will be denied	YOU PAY	
Inpatient Facility Semi-private Room (21 days per Plan year)	♦ *20%	♦*50%
Inpatient Facility Ancillary (21 days per Plan year)	♦ *20%	♦*50%
Inpatient Facility Physician Visits (21 visits per Plan year, 1 visit per day)	♦ *20%	♦*50%
Physician Office Visits (15 visits per Plan year, 1 visit per day)		
Psychologist / Clinical Social Worker / APRN	$25	♦*50%
Psychiatrist	$50	♦*50%
OTHER LIMITED BENEFITS	YOU PAY	
Adoption Indemnity Benefit	The Plan pays a maximum $2,500 towards adoption expenses per child	
TMJ Syndrome treatment	Not Covered	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN) ($10,000 per Plan year)	♦ *50%	♦*50%
Significant Medication (during first 12 months after FDA approval)	*50%	♦*50%
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	♦*50%
Primary Infertility ($1,500 per Plan year, $5,000 per lifetime)	♦ *50%	Not Covered

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 Educators Customer Service Department.

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