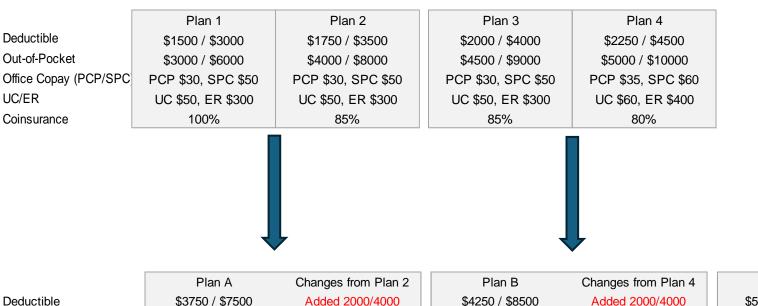
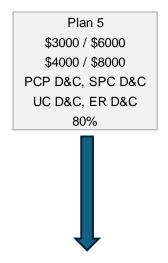
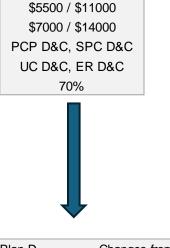
Alpine School District 2024-25 Plan Changes







Plan 6

Deductible Out-of-Pocket Office Copay (PCP/SPC) UC/ER Coinsurance Rx

\$3750 / \$7500 Added 2000/4000 \$6000 / \$12000 Added 2000/4000 PCP \$30, SPC \$50 No Change UC \$50, ER \$300 No Change 85% No Change Mail Order, Specialty, DAW1 Garner Added a 2000/4000 HRA

\$4250 / \$8500 \$7000 / \$14000 Added 2000/4000 No Change PCP \$35, SPC \$60 UC \$60, ER \$400 No Change 80% No Change Mail Order, Specialty, DAW1 Added a 2000/4000 HRA

Plan C Changes from Plan 5 \$5000 / \$10000 Added 2000/4000 \$6000 / \$12000 Added 2000/4000 No Change PCP D&C, SPC D&C UC D&C, ER D&C No Change 80% No Change Specialty and DAW1 Added a 2000/4000 HRA

Plan D \$7000 / \$14000 \$8000 / \$16000 PCP D&C, SPC D&C UC D&C, ER D&C 70%

Changes from Plan 6 Added 1500/3000 Added 1000/2000 No Change No Change No Change Specialty and DAW1 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	P	Plan A Plan B		lan 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%	4 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	N	None		\$250 / \$750		Medical Deductible Applies to Rx	
Specialty Pharmacy	Generic - 2	Generic - 25% (\$150 Max)		●Generic - 25% (\$150 Max)		◆Generic - 25% (\$150 Max)	
	Preferred - 2	Preferred - 25% (\$250 Max)		●Preferred - 25% (\$250 Max)		5% (\$250 Max)	
	Non-Preferred	- 30% (\$500 Max)	●Non-Preferred	1 - 30% (\$500 Max)	◆Non-Preferred	- 30% (\$500 Max)	
Specialty Pharmacy SaveOnSP Program	Must enroll to r	eceive: *\$0 Copay	Must enroll to receive: *\$0 Copay		Must enroll to re	eceive: *\$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	Pla	n 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)		% (\$150 Max)	◆Generic - 25% (\$150 Max)		◆Generic - 25% (\$150 Max)		
	Preferred - 25	% (\$250 Max)	●Preferred - 25% (\$250 Max)		◆Preferred - 25% (\$250 Max)		◆Preferred - 2	5% (\$250 Max)
	Non-Preferred -	30% (\$500 Max)	●Non-Preferred - 30% (\$500 Max) ◆Non-Preferred - 30% (\$500 Max) ◆N		◆Non-Preferred	- 30% (\$500 Max)		
Specialty Pharmacy SaveOnSP Program	Must enroll to re	ceive: *\$0 Copay	Must enroll to re	ceive: *\$0 Copay	Must enroll to re	ceive: *\$0 Copay	Must enroll to re	eceive: *\$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.



Chiropractic Therapy (20 visits per Year)

Administered by Educators Mutual Insurance Association EMI Health Customer Service 801-262-7475 or 1-800-662-5851

/ \		vice 801-262-7475 or 1-800-662-58 unded Employee Medical Benefit Pl
All services are subject to the EMI Health Maximum Allowable Charge.		
responsible for all fees in excess of the		ovider, the covered reason is
Alpine School District		e Plus
September 01, 2024 - August 31, 2025	Participating	Non-Participating
Plan A	Provider Option	Provider Option
GENERAL INFORMATION		J PAY
Benefit Accumulator		act 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		J PAY
available, member pays the copay plus the difference between the generic and the brand price)		
Participating Pharmacy (up to 30 day supply)	Gener	ic - 25%
	Preferr	ed - 35%
	Non-Prefe	erred - 45%
Non-Participating Pharmacy	Not C	Covered
Mail Order (up to 90 day supply)	Gener	ic - 25%
······································	Preferred - 3	5% (\$250 Max)
		erred - 45%
Specialty Pharmacy (up to 90 day supply)		% (\$150 Max)
All fills must be purchased through Express Scripts Specialty Pharmacy.		5% (\$250 Max)
an mis must be purchased unough Express compts opecially i marmacy.		· 30% (\$500 Max)
Specialty Pharmacy SaveOnSP Program 1-800-683-1074		Il to receive:
http://emihealth.com/pdf/saveon.pdf		Copay
PREVENTIVE SERVICES		
		J PAY
Routine Physical Exam (1 visit per Year) Routine Gynecological Exam (1 visit per Year)	Covered 100%	Not Covered
	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		JPAY
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%
njections (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%
· · · · · · · · · · · · · · · · · · ·		

\$30

♦40%

Alpine School District	Care Plus		
September 01, 2024 - August 31, 2025 Plan A	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	J 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		J PAY	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	♦ 15%	◆40%	
ACCIDENT AND LIFE THREATENING CONDITION	YOU	J PAY	
		JPAT	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Cavarad as a Davisinating Danafit to	
Ambulance Land/Air (Accident & Life-threatening)	♦20%	Covered as a Participating Benefit to	
Orthodontic Injury Treatment	♦*15%	the Maximum Allowable Charge	
Dental Injury Treatment	♦ 20%	LDAV	
TRANSPLANT BENEFIT	Ÿ	J PAY	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney MEDICAL SUPPLIES & EQUIPMENT	Covered as any other condition	Not Covered J PAY	
Diabetic Testing Supplies (90 day supply)	40%	◆40%	
Medical Supplies Medical Supplies	40 % ♦ 20%	◆40% ◆40%	
Medical Supplies (office)	Covered 100%	◆40% ◆40%	
Durable Medical Equipment/Prosthetics/Orthotic Devices			
	♦ 20% ♦ 20%	◆40% ◆40%	
Hearing Aids (\$2,500 per Year)			
Orthotic Supplies (foot inserts & arch supports) Growth Hormone	♦ 20% ♦ 20%	Not Covered ◆40%	
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT		J PAY	
	♦ 15%		
Inpatient Services (non-residential) Residential Treatment (30 days per Year)	◆15% ◆15%	♦ 40%	
		♦ 40%	
Outpatient Services	♦ 15%	♦ 40%	
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	\$30	40%	
· · ·		J PAY	
ADDITIONAL BENEFITS			
Adoption Indemnity Benefit		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



Administered by Educators Mutual Insurance Association EMI Health Customer Service 801-262-7475 or 1-800-662-5851

Self Funded Employee Medical Benefit Plan

Aplies School District September 81, 2024 - August 31, 2025 Participating Participating Provider Option O	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			
Appine Shool District				
Plan B Provider Option Provider Option Provider Option Provider Option Contract Year				
Plan B Provider Option Provider Option Provider Option Provider Option Contract Year	·			
Benefil Accumulator Contract Year				
Dependent Age Limit	GENERAL INFORMATION	YOU	J PAY	
Cut-of-Pocket Maximum Per Person/Family Per Year - Separate from and not satisfed by the Prescription Drug Deductible). Please note + Non-Prescription Drug Deductible Prescription Drug Drug Drug Drug Drug Drug Drug Drug	Benefit Accumulator	Contra	act Year	
Madrical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Pescription Dup Deductible (Pesca note + 1) with the Pescription Dup Deductible (Pesca note + 1) with the Pescription Dup Deductible (Pesca note + 1) with the Pescription Dup Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Model Deductible (Person-Family Person Person - Separate from and not satisfied by the Model Deductible (Person-Family Person Person - Separate from and not satisfied by the Model Deductible (Person-Family Person Person - Separate from and not satisfied by the Model Deductible (Person-Family Person Person - Separate from and not satisfied by the Model Deductible (Person-Family Person - Separate from and not satisfied by the Person - Separate from and not satisfied by the Person - Separate from and not satisfied by the Person - Separate from and not satisfied by the Person - Separate from and not satisfied by the Person - Separate from and not satisfied by the Person - Separate from and not satisfied by the Person - Separate from and not satisfi				
by the Prescription Drug Deductible). Please note ◆ Not-Presunthorization Platient Perality Not-Prescription Drug Deductible (Per PersoniFamily Per Year - Separate from and not satisfied by the Medical Deductible). Please note ◆ *Control of the Medical Deductible (Per PersoniFamily Per Year - Separate from and not satisfied by the Medical Deductible). Please note ◆ *Control of the Medical Deductible (Per PersoniFamily Per Year - Separate from and not satisfied by the Medical Deductible). Please note ◆ *Control of the Medical Deductible (Per PersoniFamily Per Year - Separate from and not satisfied by the Medical Deductible). Please note ◆ *Control of the Medical Deductible (Per PersoniFamily Per Year) Not-Perality Personifaction (Personifamily Per Year) *Control of the Medical Deductible (Per Personifamily Per Year) *Control of the Medical Deductible (Per Personifamily Per Year) *Control of the Medical Deductible (Per Personifamily Per Year) *Control of the Medical Deductible (Per Personifamily		\$7,000 / \$14,000	\$10,000 / \$20,000	
Nort Applicable S0% Reduction in Benefits Nort Applicable S0% Reduction in Payment Nort Applicable S0% Reduction in Payment Nort Applicable S0% Reduction in Payment Nort Applicable Nort Applicable S0% Reduction in Payment Nort Applicable Nort Applicable Nort Applicable Nort Applicable S0% Reduction in Payment Nort Applicable S0% Reduction in Payment Nort Applicable Nort Applicable Nort Applicable S0% Reduction in Payment Nort Applicable Nort Applicable Nort Applicable S0% Reduction in Payment Nort Applicable Nort Applicable S0% Reduction in Payment Nort Applicable N		\$4.250 / \$8.500	\$6,500 / \$13,000	
Non-President Sanction Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical Deductible). Please note • Participating Pharmacy (up to 30 day supply) Participating Pharmacy (up to 30 day supply) Participating Pharmacy (up to 30 day supply) Participating Pharmacy (up to 90 day supply) Participating Pharmacy (up to 90 day supply) Preferred - 35% (\$250 Max) Preferre				
PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic and the brand price) Prescription Drug Deducible (Per Person/Family Per Year - Separate from and not satisfied by the Medical Deducible). Please note • Participating Pharmacy (up to 30 day supply) **Generic - 25% **Preferrer - 35% **Non-Participating Pharmacy Mail Order (up to 90 day supply) **One-Perferrer - 45% **Non-Participating Pharmacy Mail Order (up to 90 day supply) **One-Perferrer - 35% **Non-Perferrer - 45% **Specialty Pharmacy (up to 90 day supply) **One-Perferrer - 45% **Specialty Pharmacy (up to 90 day supply) **One-Perferrer - 45% **Specialty Pharmacy (up to 90 day supply) **All file must be purchased through Express Scripts Specialty Pharmacy. **Preferrer - 25% (\$250 Max) **Non-Preferrer - 45% (\$150 Max) **Non-Preferrer - 25% (\$250 Max) **Non-Pref	·			
available, member pays the copay plus the difference between the generic and the brand price) Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical Deductible). Please note • Participating Pharmacy (up to 30 day supply) **Generic - 25% **Preferred - 35% **Non-Preferred - 45% Non-Participating Pharmacy Mail Order (up to 90 day supply) **Generic - 25% **Preferred - 35% (\$250 Max) **Non-Preferred - 35% (\$250 Max) **Non				
saitsfied by the Medical Deductible). Please note • Participating Pharmacy (up to 30 day supply) • Generic - 25% • Preferred - 35% • Non-Participating Pharmacy Mail Order (up to 90 day supply) • Generic - 25% • Preferred - 45% Non-Participating Pharmacy Mail Order (up to 90 day supply) • Generic - 25% • Preferred - 45% • Preferred - 45% Specialty Pharmacy (up to 90 day supply) Alf fills must be purchased through Express Scripts Specialty Pharmacy. • Preferred - 45% • Specialty Pharmacy (up to 90 day supply) Alf fills must be purchased through Express Scripts Specialty Pharmacy. • Preferred - 25% (\$550 Max) • Non-Preferred - 45% • Non-Preferred - 30% (\$500 Max) • Non-Preferred - 20% (\$500 Max) • No	available, member pays the copay plus the difference between the generic	100	JEAN	
saitsfied by the Medical Deductible). Please note • Participating Pharmacy (up to 30 day supply) • Generic - 25% • Preferred - 45% Non-Participating Pharmacy Mail Order (up to 90 day supply) • Generic - 25% • Preferred - 45% Non-Participating Pharmacy Mail Order (up to 90 day supply) • Generic - 25% • Preferred - 35% (£50 Max) • Non-Preferred - 45% Specialty Pharmacy (up to 90 day supply) Alf fills must be purchased through Express Scripts Specialty Pharmacy. • Preferred - 25% (£50 Max) • Non-Preferred - 35% (£50 Max) • Non-Preferred - 35% (£50 Max) • Non-Preferred - 25% (£50 Max) • Non-Preferred - 25% (£50 Max) • Non-Preferred - 25% (£50 Max) • Non-	Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not	ФО	N 6750	
Preferred - 35% Non-Participating Pharmacy Mail Order (up to 90 day supply) Specialty Pharmacy (up to 90 day supply) Specialty Pharmacy (up to 90 day supply) Specialty Pharmacy (up to 90 day supply) Alf fills must be purchased through Express Scripts Specialty Pharmacy. Specialty Pharmacy (up to 90 day supply) Alf fills must be purchased through Express Scripts Specialty Pharmacy. Specialty Pharmacy SaveOnSP Program 1-800-683-1074 Intelly/emhealth com/pdfsaveon.pdf PREVENTIVE SERVICES Routine Pys Services Covered 100% Not Covered Not Covered Routine Pys Services Routine Pys		\$250	001610	
Non-Participating Pharmacy	Participating Pharmacy (up to 30 day supply)	●Gene	ric - 25%	
Non-Participating Pharmacy Mail Order (up to 90 day supply) - Generic - 25% (S20 Max) - Preferred - 35% (S20 Max) - Preferred - 45% Specialty Pharmacy (up to 90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy. - Preferred - 45% Specialty Pharmacy (up to 90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy. - Preferred - 25% (S250 Max) - Non-Preferred - 35% (S250 Max) - Non-Preferred - 25%				
Again Order (up to 90 day supply)				
Preferred - 35% (\$250 Max)	1 0 7			
Specialty Pharmacy (up to 90 day supply) Alf fills must be purchased through Express Scripts Specialty Pharmacy. Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf PREVENTIVE SERVICES Routine Ophosic Exam (1 visit per Year) Routine Physical Exam (1 visit per Year) Routine Pap Smear & Mammogram (1 per Year) Routine Pap Smear & Mammogram (1 per Year) Routine Well-Baby Exams Covered 100% Not Covered Routine Well-Baby Exams Routine Pap Smoath Exams (Routine Routine	Mail Order (up to 90 day supply)			
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Participating Provider Option Provider Opt	Alpine School District	Care Plus		
Allergy Treatment/Serum S50 per person per Year, then covered 100% Wedical/Surgical/Matermly/Intensive Care (semi-private room) Medical/Surgical/Matermly/Intensive Care (semi-private room) Medical/Surgical/Matermly/Intensive Care (semi-private room) Medical/Surgical/Matermly/Intensive Care (semi-private room) Medical/Surgical/Matermly/Intensive Care (semi-private room) Medical/Surgical Matermly/Intensive Care (semi-private room) Medical/Surgical Matermly/Intensive Care (semi-private room) Medical/Surgical Care (Outpatient) Million Diagnosts Test, X-ray, Lab (Ingellent) Million Diagnosts Test, X-ray, Lab (Ingellent) Medical/Surgical Care (Clinic S60 440% Million Diagnosts Test, X-ray, Lab (Quipatient) Medical/Surgical Care (Clinic S60 440% Million Diagnosts Test, X-ray, Lab (Quipatient) Medical/Surgical Care (Clinic S60 440%	September 01, 2024 - August 31, 2025	Participating	Non-Participating	
Covered 100%	Allergy Testing			
HOSPITALFACILITY PENETIS Physician & Professional Services are not included in this section.)	Allergy Treatment/Serum		Not Covered	
Medical/Surgical/Maternity/Intensive Care (sem-private room) +20% +40%			J PAY	
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Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney MEDICAL SUPPLIES & EQUIPMENT Diabetic Testing Supplies (90 day supply) Medical Supplies (90 day supply) Medical Supplies (office) Durable Medical Equipment/Prosthetics/Orthotic Devices Hearing Aids (\$2,500 per Year) Orthotic Supplies (foot inserts & arch supports) Growth Hormone Growth Hormone MENTAL HEALTH & DRUG/ALCOHOL TREATMENT Inpatient Services (non-residential) Residential Treatment (30 days per Year) Outpatient Services Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist ADDITIONAL BENEFITS Adoption Indemnity Benefit The Plan pays a maximum of \$4,000 towards adoption expenses. TMJ Syndrome Not Covered			LDAV	
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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				
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 \$35 *40% 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 Orthograthic/Mandibular Osteotomy Not Covered Not Covered Total Parenteral Nutrition (TPN) **50% Not Covered Infertility (\$5,000 per lifetime infertility maximum.) **50% Not Covered Reduction Mammoplasty **50% Not Covered				
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Hearing Aids (\$2,500 per Year) Orthotic Supplies (foot inserts & arch supports) Growth Hormone MENTAL HEALTH & DRUG/ALCOHOL TREATMENT Inpatient Services (non-residential) Residential Treatment (30 days per Year) Outpatient Services Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist ADDITIONAL BENEFITS Adoption Indemnity Benefit The Plan pays a maximum of \$4,000 towards adoption expenses. TMJ Syndrome Orthognathic/Mandibular Osteotomy Total Parenteral Nutrition (TPN) Not Covered Infertility (\$5,000 per lifetime. Medications that require prior authorization will apply toward the \$5000 lifetime infertility maximum.) P40% 100				
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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				
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				
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				
Residential Treatment (30 days per Year) Outpatient Services Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist ADDITIONAL BENEFITS Adoption Indemnity Benefit The Plan pays a maximum of \$4,000 towards adoption expenses. TMJ Syndrome Orthognathic/Mandibular Osteotomy Total Parenteral Nutrition (TPN) Not Covered Infertility (\$5,000 per lifetime. Medications that require prior authorization will apply toward the \$5000 lifetime infertility maximum.) Reduction Mammoplasty A00% A40% YOU PAY The Plan pays a maximum of \$4,000 towards adoption expenses. Not Covered				
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Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist ADDITIONAL BENEFITS Adoption Indemnity Benefit The Plan pays a maximum of \$4,000 towards adoption expenses. TMJ Syndrome Orthognathic/Mandibular Osteotomy Total Parenteral Nutrition (TPN) Infertility (\$5,000 per lifetime. Medications that require prior authorization will apply toward the \$5000 lifetime infertility maximum.) Reduction Mammoplasty \$35 YOU PAY The Plan pays a maximum of \$4,000 towards adoption expenses. Not Covered	, , , ,			
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Adoption Indemnity Benefit Adoption Indemnity Benefit The Plan pays a maximum of \$4,000 towards adoption expenses. TMJ Syndrome Orthognathic/Mandibular Osteotomy Not Covered		\$35	♦ 40%	
Adoption Indemnity Benefit The Plan pays a maximum of \$4,000 towards adoption expenses. TMJ Syndrome Not Covered		. You	LDAY	
TMJ Syndrome Orthognathic/Mandibular Osteotomy Total Parenteral Nutrition (TPN) Infertility (\$5,000 per lifetime. Medications that require prior authorization will apply toward the \$5000 lifetime infertility maximum.) Reduction Mammoplasty Not Covered Not Covered Not Covered Not Covered 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	<u>'</u>			
Total Parenteral Nutrition (TPN)				
Infertility (\$5,000 per lifetime. Medications that require prior authorization will apply toward the \$5000 lifetime infertility maximum.) Reduction Mammoplasty **50% Not Covered Not Covered				
toward the \$5000 lifetime infertility maximum.) Reduction Mammoplasty *50% Not Covered Not Covered		♦ *50%	Not Covered	
,				
Autism Applied Behavior Analysis \$20%	Reduction Mammoplasty		Not Covered	
740/0 ¥40/0	Autism Applied Behavior Analysis	♦ 20%	4 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



Administered by Educators Mutual Insurance Association EMI Health Customer Service 801-262-7475 or 1-800-662-5851

Self Funded Employee Medical Benefit Plan

		nded Employee Medical Benefit Pla	
All services are subject to the EMI Health Maximum Allowable Charge.		vider, the Covered Person is	
responsible for all fees in excess of the		DI	
Alpine School District	Care Plus		
September 01, 2024 - August 31, 2025	Participating Provider Option	Non-Participating	
Plan C QHDHP GENERAL INFORMATION		PAY Provider Option	
Benefit Accumulator	:	ct 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)		PAY	
Participating Pharmacy (up to 30 day supply)	♦Generi	ic - 20%	
	♦Preferre	ed - 30%	
	♦Non-Prefe	erred - 40%	
Non-Participating Pharmacy	Not Co		
Mail Order (up to 90 day supply)		ic - 20%	
	♦Preferre		
		erred - 40%	
Specialty Pharmacy (up to 90 day supply)	♦Generic - 25		
All fills must be purchased through Express Scripts Specialty Pharmacy.	♦Preferred - 25	,	
O	♦Non-Preferred -	, ,	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074	Must enroll		
http://emihealth.com/pdf/saveon.pdf		Copay	
PREVENTIVE SERVICES		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) Routine Pap Smear & Mammogram (1 per Year)	Covered 100% Covered 100%	Not Covered Not Covered	
Routine Pap Shlear & Mahimogram (1 per Tear) 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		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%	4 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	Care	e Plus
September 01, 2024 - August 31, 2025	Participating	Non-Participating
Plan C QHDHP	Provider Option	Provider Option
Allergy Testing	♦ 20%	♦ 40%
Allergy Treatment/Serum	♦ 20%	Not Covered
HOSPITAL/FACILITY BENEFITS	YOL	J PAY
(Physician & Professional Services are not included in this section.)		
Medical/Surgical/Maternity/Intensive Care (semi-private room)	• 20%	4 0%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦ 20%	♦ 40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of	♦20%	♦ 40%
discharge from Hospital Confinement)		
Medical/Surgical Care (Outpatient)	♦ 20%	4 0%
Emergency Room (ER)	♦ 20%	♦ 20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦ 20%	4 0%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦ 20%	♦ 40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦ 20%	4 0%
Newborn	♦ 20%	♦ 40%
InstaCare/Urgent Care Clinic	♦ 20%	♦ 40%
Eligible Preventive Services	Covered 100%	Not Covered
REHABILITATION THERAPY BENEFIT	YOL	J PAY
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per	♦ 20%	♦ 40%
person per Year)		
ACCIDENT AND LIFE THREATENING CONDITION		J PAY
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	0 0 0 0 0
Ambulance Land/Air (Accident & Life-threatening)	♦20%	Covered as a Participating Benefit to
Orthodontic Injury Treatment	♦20%	the Maximum Allowable Charge
Dental Injury Treatment	♦ 20%	LDAY
TRANSPLANT BENEFIT		J PAY
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT		J PAY
Diabetic Testing Supplies (90 day supply)	♦30%	♦ 40%
Medical Supplies Medical Supplies (office)	♦20%	◆40% ◆40%
Medical Supplies (office) Durable Medical Equipment/Prosthetics/Orthotic Devices	♦ 20% ♦ 20%	◆40% ◆40%
	♦ 20%	◆40%
Hearing Aids (\$2,500 per Year) Orthotic Supplies (foot inserts & arch supports)	◆20%	◆40% ◆40%
Growth Hormone	♦ 20%	◆40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT		J 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%	4 0%
ADDITIONAL BENEFITS	YOL	J PAY
Adoption Indemnity Benefit		,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%
Over the end of the en	. = 5 / 0	

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



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	S in excess of the waximum Allowable Charge. Care Plus		
September 01, 2024 - August 31, 2025	Participating	Non-Participating	
Plan D QHDHP	Provider Option	Provider Option	
GENERAL INFORMATION		J PAY	
Benefit Accumulator	Contra	act Year	
Dependent Age Limit	2	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	YOU	J PAY	
and the brand price)			
Participating Pharmacy (up to 30 day supply)	♦Gener	ric - 20%	
a analysis is a many (ap to co day cappy)		red - 30%	
	♦Non-Pref	erred - 40%	
Non-Participating Pharmacy	Not C	overed	
Mail Order (up to 90 day supply)	♦Gener	ric - 20%	
	♦Preferr	red - 30%	
		erred - 40%	
Specialty Pharmacy (up to 90 day supply)		5% (\$150 Max)	
All fills must be purchased through Express Scripts Specialty Pharmacy.		5% (\$250 Max)	
		- 30% (\$500 Max)	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074		I to receive:	
http://emihealth.com/pdf/saveon.pdf		Copay	
PREVENTIVE SERVICES		J PAY	
Routine Physical Exam (1 visit per Year)	Covered 100%	Not Covered	
Routine Gynecological Exam (1 visit per Year) Family History Exam (1 visit per Year)	Covered 100% Covered 100%	Not Covered Not Covered	
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	Not Covered 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	J 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) Minor Diagnostic Test, Radiology, Lab (office)	♦30% ♦30%	◆50% ◆50%	
Minor Diagnostic Test, Radiology, Lab (diffee) Minor Diagnostic Test, Radiology, Lab (Inpatient)	◆30%	◆50% ◆50%	
Minor Diagnostic Test, Radiology, Lab (Inpatient) Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦30 %	◆50%	
Injections (office)	♦30 %	◆50%	
Surgery (office)	♦ 30%	<u></u> ♦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	♦ 30%	♦ 50%	
Supplies and Equipment) Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or	♦ 30%	♦ 50%	
pulmonary - 20 visits per Year per injury/illness)			
Chiropractic Therapy (20 visits per Year)	♦ 30%	♦50%	

Alpine School District	Care Plus	
September 01, 2024 - August 31, 2025	Participating	Non-Participating
Plan D QHDHP	Provider Option	Provider Option
Allergy Testing	♦ 30%	♦ 50%
Allergy Treatment/Serum	♦ 30%	Not Covered
HOSPITAL/FACILITY BENEFITS	YOU PAY	
(Physician & Professional Services are not included in this section.)		
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	♦30%	♦ 50%
discharge from Hospital Confinement)		
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	♦ 30%	♦ 50%
person per Year)		
ACCIDENT AND LIFE THREATENING CONDITION	YOU PAY	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	0 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Ambulance Land/Air (Accident & Life-threatening)	♦30%	Covered as a Participating Benefit to
Orthodontic Injury Treatment	♦30%	the Maximum Allowable Charge
Dental Injury Treatment	♦ 30%	LDAY
TRANSPLANT BENEFIT		J PAY
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	,	J PAY
Diabetic Testing Supplies (90 day supply)	♦30%	♦ 50%
Medical Supplies	♦30%	♦ 50%
Medical Supplies (office)	♦ 30% ♦ 30%	◆50% ◆50%
Durable Medical Equipment/Prosthetics/Orthotic Devices	◆30% ◆30%	◆50% ◆50%
Hearing Aids (\$2,500 per Year) Orthotic Supplies (foot inserts & arch supports)	◆30% ◆30%	♦50% ♦50%
Growth Hormone	◆30% ◆30%	♦50% ♦50%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	▼50% YOU PAY	
Inpatient Services (non-residential)	♦30%	♦50%
Residential Treatment (30 days per Year)	◆30%	♦ 50%
Outpatient Services	◆30% ◆30%	◆50%
Physician Office Visits		
Psychologist / LCSW / APRN / Psychiatrist	♦ 30%	♦ 50%
ADDITIONAL BENEFITS	YOL	J 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%
Over the end of the en	. 50 /0	. 5570

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