
SUMMARY PLAN DESCRIPTION
AND
PLAN DOCUMENT

FOR

THE UTAH STATE UNIVERSITY - COLLEGE OF EASTERN UTAH
SELF-FUNDED
EMPLOYEE BENEFIT PLAN
(PREMIER DENTAL)

As of July 1, 2019

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Utah State University - College of Eastern Utah (the “Plan Sponsor”), as of July 1, 2019, hereby **amends and restates** The Utah State University - College of Eastern Utah Self-Funded Employee Dental Benefit Plan (the “Plan”), which was originally adopted by Plan Sponsor.

EFFECTIVE DATE

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the “Effective Date”).

ADOPTION OF THE PLAN DOCUMENT

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed. Receipt of payment to the Claims Administrator will be deemed confirmation of receipt and acceptance of this Plan Document.

PLAN SPONSOR

Utah State University - College of Eastern Utah


Doug Bullock (Dec 10, 2019)

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GENERAL PLAN INFORMATION

UTAH STATE UNIVERSITY - COLLEGE OF EASTERN UTAH has adopted this Plan for the benefit of its eligible Employees and their eligible Dependents. This document provides a summary of the benefits provided under the Plan as of July 1, 2019, and is also the formal plan document of the Plan.

Please note that capitalized terms used in this document are defined either the first time they are used or in the “Definition of Terms” section at the end of this document.

TYPE OF PLAN

All benefits under the Plan are self-insured by the Plan Sponsor. Benefits under the Plan are funded by contributions by the Plan Sponsor and/or Participants.

TYPE OF ADMINISTRATION

The Plan Sponsor is the Plan Administrator. The Plan Sponsor has entered into an agreement with Educators Mutual Insurance Association (“EMI Health”) as a third-party administrator to assist the Plan Sponsor in the Plan’s claims administration and certain other administrative matters.

PLAN NAME

The Utah State University - College of Eastern Utah Self-funded Employee Benefit Plan (Premier Dental)

EFFECTIVE DATE OF PLAN AS AMENDED AND RESTATED: July 1, 2019

PLAN YEAR ENDS: June 30, 2020

RENEWAL

This Plan may automatically be renewed for 12-month terms unless the Plan Sponsor notifies EMI Health in writing of its intent to terminate the Plan at least 60 days prior to the end of the current term.

EMPLOYER/PLAN SPONSOR INFORMATION

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CLAIMS ADMINISTRATOR

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Murray, Utah 84107
Telephone: (801) 262-7476
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Website: www.emihealth.com

GROUP NUMBER: 0112

AMENDMENT OR TERMINATION

The Plan Sponsor reserves the right to modify, suspend, or terminate the Plan at any time. The Plan Sponsor does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement.

The Table of Allowances may be updated as deemed necessary by the Plan Sponsor and EMI Health. After the effective date of a change in the Table of Allowances, all benefits will be paid according to the new Table of Allowances.

Benefit changes to this Plan will apply to all Covered Persons on the date amended benefits become effective.

The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrator, the Claims Administrator, or any other person. In the event an oral statement conflicts with the written terms of this Plan, the Plan terms will control.

NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or any inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

DISCRETIONARY AUTHORITY

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies, and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

EMI HEALTH PREMIER DENTAL PLAN

Diagnostic/Preventive Benefits

- Oral examinations two times per Contract Year
- X-rays are covered as follows:
 - Full mouth – once every three years
 - Supplementary bitewings – up to four procedures, twice per Contract Year
 - Supplementary periapical – six procedures per Contract Year
- Cleaning and scaling teeth (prophylaxis) two times per Contract Year
- Application of fluoride in conjunction with cleaning two times per Contract Year, limited to Dependent children up to the 16th birthday

Space Maintainers

- Space maintainers used to maintain the present position of a tooth following an extraction for Dependent children up to the 16th birthday

Sealants

- Sealants for Dependent children up to the 16th birthday

Basic Services

- Restoration of decayed teeth with amalgam, synthetics, or plastic, up to one restoration per surface. Repairs to restorations are allowed only once every 18 months, regardless of the reason. Tooth preparation, temporary restorations, cement bases, impressions, and local anesthesia are all considered part of the restoration and are covered only when included in the charge for the entire process.

Major Services

- Gold onlays and crowns are covered if teeth cannot be restored with amalgam, synthetic, porcelain, or plastic. Benefits are payable once every five years for the same tooth.

Endodontic Services

- Endodontic treatment, including root canal therapy. One pulp cap per tooth is allowed. Bases are not covered.

Periodontic Services

- Periodontic services are limited to one perio maintenance (two per calendar year in lieu of preventive cleaning); root scaling and planing (once per quadrant of mouth in any 24 month period); gingivectomy, gingival curettage; osseous surgery including flap entry and closure; pedicle or free soft tissue grafts; full mouth debridement (one every five years).

Prosthodontic Services

- Initial installation of a removable or fixed partial or complete denture once every five years. Fixed bridges for patients under age 16 are covered up to the amount allowed for a removable partial denture.
- One laboratory reline is covered following the initial installation of a denture and once every three years thereafter. Office relines are not a covered benefit.
- Implants are covered, limited to \$225. All services and products related to the implant (including, but not limited to, the anchor and the post) apply toward the implant limit.

Crowns associated with implants fall under the benefit for crowns and are subject to any limits applicable to that benefit.

- Replacement of missing teeth with complete or partial dentures, fixed bridges, or implants is covered.
- Replacement of a denture or implant that is no longer serviceable is covered once every five years.

Oral Surgery Services

- Extractions and other oral surgery involving procedures for simple and complicated extractions of impacted or erupted teeth, including frenectomy, alveolectomy, removal of palatal and mandibular tori, and crown exposure. Post-operative care and removal of sutures are considered part of the surgical procedure and are covered only when included in the charge for the entire surgical procedure.

Anesthesia Services

- General anesthesia, including intravenous sedation, is limited to age seven and under, once per Contract Year. General anesthesia for the extraction of impacted teeth for individuals age eight and over is covered to the Table of Allowances, based on necessity, not for anxiety management.

Orthodontic Services

Orthodontic services are covered for functionally related problems, not for Cosmetic purposes, for eligible unmarried Dependent children up to the 19th birthday.

- Initial diagnostic records (study models, facial photographs, etc.) are covered only if eligible orthodontic treatment is rendered.
- Orthodontic treatment, including diagnostic procedures, X-rays, and appliance therapy.
- Amounts paid under a previous dental care plan for a case in progress, which is defined as the placement of bands, will be deducted from the maximum amount payable for orthodontic benefits under this Plan.

Waiting Periods

Failure to enroll at first opportunity results in a 12 month waiting period.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be \$300 or more, a predetermination of benefits is recommended. The Dentist must itemize all recommended services and costs and attach all supporting documents, including x-rays. EMI Health will notify the Dentist of the benefits payable under the policy. The Member and the Dentist can then decide on the course of treatment, knowing in advance how much EMI Health will pay.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an alternate treatment clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient receives a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

PREMIER DENTAL PLAN EXCLUSIONS

Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered by the Plan.

EMI Health Premier Dental Plan does not pay for any of the following:

1. Services received by a Covered Person before coverage under the Plan became effective or after coverage under the Plan has terminated.
2. Expenses for preparing dental reports, itemized bills, or claim forms.
3. Illness or injury caused by the negligent or wrongful act of another, or for which the Covered Person is covered by any workers' compensation or similar law; except that EMI Health may advance benefits to or on behalf of the Covered Person in such situations, subject to EMI Health's right of Subrogation and reimbursement set forth herein.
4. Illness or injury that a Covered Person incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Covered Person, except that the Plan may elect to advance benefits to or on behalf of the Covered Person in either situation, subject to the Plan's rights of Subrogation and reimbursement set forth herein.
5. Illness or injury for which the Covered Person is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, underinsured motorist coverage or uninsured motorist coverage, except as otherwise provided herein, or as otherwise provided by law.
6. Charges for services related to birth defects or cosmetic surgery or dentistry for solely Cosmetic reasons including, but not limited to, bonding and veneers.
7. Any procedure started prior to the date the patient became covered for such services under this policy. This Exclusion does not apply to covered orthodontic benefits for a case in progress.
8. Medical care, confinement, treatment, services, use of facilities, or supplies for which charges are made by a facility, including freestanding nursing home, rest home, or similar establishment.
9. Plaque control programs, oral hygiene instruction, and dietary instruction.
10. Myofunctional therapy.
11. Lab costs for an oral tissue biopsy.

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12. Treatment to correct problems with the way teeth meet or to adjust bite (alter vertical dimensions or restore or equilibrate occlusion) except as covered under orthodontia.
 13. Care, treatment, operations, supplies, appliances, aids, devices, or drugs that are not FDA approved.
 14. Care, supplies, treatment, and/ or services for any Injury or illness which incurred while taking part or attempting to take part in an Act of Aggression or an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental conditions).
 15. Care, treatment, operations, or supplies that are illegal, Experimental, Investigational, or for research purposes by the United States medical profession that are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted dental/medical practices.
 16. Expenses in connection with transportation or mileage reimbursement.
 17. Expenses including, but not limited to, air fare, meals, accommodations, and car rental.
 18. Medications labeled "Caution, Limited by Federal Law to Investigational Use" or experimental drugs.
 19. Services that are not Medically Necessary or Cosmetic services including veneers, special techniques, precious metals used for removable appliances other than orthodontics, precision attachments for partial dentures or bridges, and personal characterization.
 20. Any procedure or appliance to correct or treat temporomandibular joint dysfunction (TMJ).
 21. Transplants, reimplantations, and associated appliances or services rendered in conjunction with Cosmetic implants. This exclusion does not apply to otherwise covered crowns.
 22. Hospital services.
 23. Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.
 24. Temporary restorations, appliances, or procedures of any nature, except that temporary restorations are covered when included in the charge for the restoration process.
 25. Replacement of lost, stolen, or damaged dentures, except once every five years.
 26. Procedures, appliances, or restorations, other than those for replacement of structure loss from caries, that are necessary to alter, restore, or maintain occlusion by any of the following: realignment of teeth, periodontal splinting, gnathological recordings,

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- equilibration, treatment of disturbances of the temporomandibular joint (TMJ), orthognathic procedures.
27. Hypnosis and related analgesia.
 28. Restorative dental services in connection with an overdenture.
 29. Expenses for services required due to complications associated with, or due to, non-covered services, and where applicable, reversal of non-covered services.
 30. Services rendered by anyone other than a licensed Dentist and when necessary and customary, as determined by the standards of generally accepted dental practice.
 31. Services for injury resulting from war or any act of war, whether declared or undeclared.
 32. Care, treatment, or services the Covered Person is not, in the absence of this policy, legally obligated to pay, except as otherwise provided by law.
 33. Care, treatment, or services rendered by any Provider who ordinarily resides in the same household (e.g. Spouse, parent).
 34. Benefits for services or treatments covered under any medical plan.
 35. Expenses for appointments scheduled but not kept, telephone consultations, or services delivered remotely via email or other telecommunication technologies.
 36. Expenses for shipping, handling, postage, sales tax, interest, or finance charges.
 37. Charges for completion or submission of insurance forms.
 38. Prescription drugs and over-the-counter medication.
 39. Charges for care, treatment, or surgical procedures that are unnecessary or in excess of the Schedule of Benefits or the Table of Allowance.
 40. The application of a dental sealant on any tooth that has been previously treated with a temporary or permanent restoration.
 41. The application of dental sealants on all Anterior teeth whether Deciduous or permanent teeth.
 42. Chemotherapeutic injections.
 44. All other services not specified as covered benefits or not specifically included in the contract with the Employer, including but not limited to, procedures not listed on the current dental fee schedule.

ELIGIBILITY AND PARTICIPATION

Plan Administration

The EMI Health Premier Dental Plan is administered by Educators Mutual Insurance Association.

Eligibility

An Employee and his Dependents are eligible for participation and coverage under this Plan if the Employee is a Full-time Employee of the Employer. Dependents of the Employee eligible for coverage include Dependent children from birth to the 26th birthday and the Employee's Spouse. Children may include stepchildren, children legally placed for adoption, legally adopted children, and children for whom the Employee has legal guardianship. Coverage for an adopted child of a Participant is provided from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth. Coverage ends if the child is removed from placement prior to being legally adopted. A Dependent child's coverage may be extended beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Participant for support and maintenance. The Participant must furnish written proof of disability and dependency to EMI Health within 31 days after the child reaches 26 years of age. EMI Health may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. (Please refer to Dependent in the "Definition of Terms" section for more information.)

Changes in Covered Person Information

Participants should notify EMI Health within 31 days whenever there is a change in a Covered Person's situation that may affect the Covered Person's enrollment eligibility or status.

Enrollment

To enroll, the Employee must complete an enrollment application and file it with his Employer within 31 days of his employment date, or during a subsequent Open Enrollment period. A Participant is not entitled to change his coverage elections during the plan year, except as provided in the *Special Enrollment* section.

When Coverage Begins

If the Employee enrolls within 30 days of his employment, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such 30-day period) becomes effective on the first day of active employment (or as otherwise specified by the Employer) subject to the receipt of a timely application.

If the Employee enrolls during an Open Enrollment period, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such Open Enrollment period) becomes effective the first day of the following plan year.

If the Employee enrolls during a Special Enrollment period, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such Special Enrollment period) becomes effective as provided in the *Special Enrollment* section.

Special Enrollment

Special Enrollment Period When Other Coverage Terminates

If an Employee declined participation for himself and/or his eligible Dependents and, when enrollment was previously declined, the Employee and/or his eligible Dependents were covered under another group plan or had other insurance coverage, the Employee will have a Special Enrollment period if when the Employee declined enrollment for himself and/or his eligible Dependents, the Employee and/or his eligible Dependents

1. Had COBRA continuation coverage under another plan and such continuation coverage has since been exhausted, and the Employee elects coverage for himself or herself and/or his or her eligible Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor within 31 days of such cessation; or
2. Had coverage through Medicaid or the Children's Health Insurance Program (CHIP) that has been terminated as a result of loss of eligibility of coverage, and the Employee elects coverage for himself or herself and/or his or her eligible Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor within 60 days of such cessation; or
3. If the other coverage was not under COBRA, Medicaid, or CHIP, either the other coverage has been terminated as a result of loss of eligibility of coverage or employer contributions towards such coverage have been terminated, and the Employee elects coverage for himself or herself and/or his or her eligible Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor within 30 days of such cessation. (**Note:** Loss of eligibility of coverage includes a loss due to legal separation, divorce, death, termination of employment, reduction in hours worked, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or intentional misrepresentation.)

If the Employee meets the above conditions coverage under the Plan will be effective as of the date such previous coverage ceased.

Special Enrollment Period for Approval to Receive Premium Assistance

The Employee and his eligible Dependents may enroll for coverage (even if He previously declined coverage for himself and/or his eligible Dependents) if the Employee is approved to receive a Premium Assistance. To enroll during this Special Enrollment period, the Employee must enroll in the Plan within 60 days from the date on which He receives written notification that He is eligible to receive Premium Assistance. Coverage will be effective the first day of the month immediately following enrollment. This provision does not modify any requirement related to premiums that apply under the Plan to a similarly situated eligible Employee or Dependent.

Special Enrollment Period for Acquisition of Dependent

The Employee and/or his new eligible Dependent may enroll for coverage (even if He previously declined coverage for himself and/or his eligible Dependents) if the Employee acquires such new eligible Dependent due to marriage, birth, adoption, or placement for adoption. In addition, the Employee may also enroll his Dependent Spouse if the Employee acquires a new Dependent due to marriage, birth, adoption, or placement for adoption. To enroll during this Special Enrollment period, the Employee must enroll within 31 days of the event (e.g., marriage, birth, adoption, or placement for adoption). Coverage will be effective as follows:

1. In the case of marriage, the marriage date; or
2. In the case of an eligible Dependent's birth, the date of such birth; or
3. In the case of adoption, or placement for adoption, the coverage for an adopted child of a Participant is provided from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

Termination of Coverage

Unless eligible for continuation coverage under COBRA, a Covered Person's participation under the Plan ceases on the earliest of the following:

For the Participant and covered Dependents, coverage will end on the 16th of the month if employment termination occurs between the 1st and the 15th of the month, or the 1st day of the following month if employment termination occurs between the 16th and last day of the month, or the date specified by the Employer, except, nine month base Employees who terminate at the end of the academic year are covered through the last day of the month in which the academic year is completed and retiring Employees are covered through the last day of the month in which they retire;

- For the Participant and covered Dependents, the last day of the month for which coverage has been paid, in the event any required Participant contributions are not made (subject to the 31-day Grace Period);
- For covered Dependents, other than the Participant's Spouse, the individual ceases to be an eligible Dependent on the last day of the calendar month coinciding with the Dependent's 26th birthday;
- For covered Spouse, the date the divorce from the Participant is final;
- For the Participant and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
- For the Participant and covered Dependents, the date this Plan is terminated; and

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- For any Covered Person, the discovery of fraud or intentional material misrepresentation of material fact on the part of the Covered Person in either the enrollment process or in the use of services or facilities, including any misuse of a Plan ID card. (Note: If a Covered Person's coverage is terminated under this provision based on fraud, the termination of coverage will relate back to the effective date of coverage and EMI Health may recover any overpayments from the Covered Person such that EMI Health and the Covered Person are returned to the same financial position as if no coverage had ever been in force. If the Covered Person's coverage is terminated under this provision based on intentional material misrepresentation of material fact, the termination of coverage will relate back to the date the misrepresentation occurred and EMI Health may recover any overpayments from the Covered Person. Termination of a Participant's coverage for cause will also result in the termination of coverage of the Participant's covered Dependents.)

A Participant is not entitled to voluntarily terminate coverage for himself or his covered Dependents during the plan year, unless He experiences a Special Enrollment qualifying event (e.g. marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). If the Participant experiences a Special Enrollment qualifying event He may elect to terminate coverage for himself and/or his Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor, within 30 days of such event.

Family Medical Leave Act (FMLA)

A Participant who goes on a leave under the Family Medical Leave Act (FMLA) has the following rights during such leave:

- A Participant may continue his coverage and the coverage of his covered Dependents during an FMLA leave provided the Participant continues to pay any required Employee portion of the cost of coverage in accordance with the Employer's FMLA leave policy. The Employer shall continue to make the same contributions toward that coverage that it would have made had the Participant not taken FMLA leave.
- If Employee portion of the cost of coverage are not paid, the Participant's and covered Dependents' coverage will be terminated 31 days after the due date of any required payment. Upon the Participant's return to work, the Participant's coverage and the coverage of any previously covered Dependents will be reinstated as long as the Participant returns to work before or following the expiration of the FMLA leave. If the Participant does not return to work before or following the expiration of the FMLA leave, the Participant will be treated as a new Employee upon his return and will be entitled to elect coverage for himself and his eligible Dependents in accordance with the rules applicable to new Employees.

Military Leave

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), a Participant who is on military duty with a uniformed service has certain rights. If the period of duty is less than 31 days, coverage will be maintained if the Participant pays any required Participant contribution. If the period of duty is for more than 31 days, EMI Health must permit the Participant to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 24 months or the period of duty. A Participant receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period can be imposed on a returning Participant and his

Dependents if the period would have been satisfied had the Participant's coverage not terminated due to the duty leave.

Qualified Medical Child Support Orders

Upon receipt of a National Medical Support Notice requiring the Participant to provide coverage for a Dependent child, EMI Health will comply with all applicable requirements of the Notice and applicable law.

CONTINUATION OF COVERAGE

COBRA Continuation of Coverage Requirements

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), a Covered Person who could otherwise lose coverage as a result of a “qualifying event” is entitled to elect to purchase medical continuation under the Plan. The coverage will be identical to the coverage provided to Covered Persons to whom a qualifying event has not occurred.

- **Qualifying Event.** A “qualifying event” is any of the following:
 - For an Employee, termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;
 - For a Spouse and eligible Dependents, death of the Employee;
 - For a Spouse, divorce or legal separation;
 - For a Spouse and eligible Dependents, loss of coverage due to the Employee becoming eligible for Medicare;
 - For a Dependent child, ceasing to qualify as a Dependent under the Plan;
 - For retirees and their Dependents, employer bankruptcy under Chapter 11.
- **Notification of EMI Health by Employee or Dependent.** The Employee or Dependent has the responsibility for notifying EMI Health in writing of a divorce, legal separation, or a child losing Dependent status under the Plan, within 60 days of the later of the date of the event or the date coverage under the Plan would be lost.
- **Notice of Continuation Rights.** When EMI Health is notified of a qualifying event, it will advise the Covered Person of the right to continue medical coverage. Continued coverage is not automatic. Covered Persons must elect to continue coverage within 60 days of the latest of the following:
 - The qualifying event;
 - The date the Covered Person is advised by EMI Health of the right to continued coverage.

Notice of the right to continued coverage to a Spouse of a covered Employee will be deemed notice to any Dependent child residing with that Spouse.

- **Payment of Premium for Continuation Coverage.** The Covered Person is required to pay a premium for the continued coverage and has the option to make these payments in monthly installments. A Covered Person will be charged the full cost of coverage under the Plan, plus an administration charge that is two percent of the group rate.

COBRA coverage will be paid for on a monthly basis. The first payment must be made within 45 days after the date coverage is elected. The first payment will include the cost of coverage retroactive to the date coverage would otherwise terminate. Failure to pay this initial premium will result in cancellation of all coverage(s), ***without notice***.

Subsequent premiums must be paid by the first of each month. Failure to pay this premium on or before the due date for any month will result in cancellation of all coverage(s), ***without notice***. If payment is received within 31 days of the premium due date, coverage will be reinstated retroactive to the date coverage was terminated for lack of premium payment.

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- **Period of Continuation Coverage.** The Period of Continuation Coverage refers to the month for which the premium has been paid. The first day of each month for which premium is paid represents the beginning of a Period of Continuation Coverage. The maximum period for continued coverage for a “qualifying event” involving termination of employment or reduced working hours is 18 months. For all other “qualifying events” the maximum period is 36 months. Other events will cause coverage to end sooner and this will occur on the earliest of any of the following:
 - The date EMI Health ceases to provide any group health plan to any Employee;
 - The date the Covered Person fails to make any required premium payments; or
 - The date the Covered Person becomes either of the following:
 - A covered Employee under any other group health plan; or
 - Eligible for Medicare.

 - **Extension of Coverage for Disabled Individuals.** If a Covered Person is disabled according to Social Security any time within the first 60 days of COBRA coverage (or a qualifying new child is so disabled within 60 days of the birth, adoption, or placement for adoption), the Covered Person may extend the 18 month COBRA coverage period to 29 months from the termination date or reduction in hours date. This extension may apply independently to each qualified Covered Person regardless of whether the disabled individual is covered under a COBRA election.

To qualify for this extension, EMI Health must be notified within 60 days of the date Social Security makes a disability determination, but before the end of the initial 18 month COBRA coverage period. If Social Security makes a determination of disability prior to the date employment ends, the Covered Person must notify EMI Health within 60 days of the date the Employee’s employment ends. EMI Health must be notified within 30 days of the date Social Security determines that the Covered Person is no longer disabled.

The cost of coverage during the 19th through 29th month extension period will be 150 percent of the group plan rate for each month provided at least one Covered Person is disabled.

COBRA coverage will end the earliest of the following:

- The first day of the month that is more than 30 days after Social Security determines that the Covered Person is no longer disabled; or
- The dates otherwise specified for terminating COBRA coverage.

COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

Coordination with Other Group Plans

When a Covered Person is covered by this Plan and another COB Plan, one plan is designated as the Primary Plan. The Primary Plan pays first and ignores benefits payable under the other plan. The Secondary Plan reduces its benefits by those payable under the Primary Plan.

Any COB Plan that does not contain a Coordination of Benefits provision that is consistent with Utah Administrative Code (U.A.C.) R590-131 (Non-conforming Plan) will be considered primary, unless the provisions of both plans state that the Conforming Plan is primary.

If a person is covered by two or more COB Plans that have Coordination of Benefits provisions, each plan determines its order of benefits using U.A.C. Rule R590-131.

A COB Plan that does not include a coordination of benefits provision may not take the benefits of another COB Plan into account when it determines its benefits.

When this Plan is secondary, EMI Health will calculate the benefits the Plan would have paid on the claim in the absence of other health coverage and apply that amount to any Allowable Expense under the Plan that is unpaid by the Primary Plan. Payment will be reduced so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all COB Plans for the claim do not exceed 100 percent of the Allowable Expense for that claim. The Plan will create to the Deductible any amounts that would have been credited to the Deductible in the absence of other health care coverage.

This COB Plan will coordinate its benefits with a COB Plan that states it is “excess” or “always secondary” or that uses order of benefit determination rules that are inconsistent with those contained in this rule on the following basis:

- If this Plan is the Primary Plan, the Plan will pay or provide its benefits on a primary basis;
- If this Plan is the Secondary Plan, EMI Health will pay or provide its benefits first, but the amount of the benefits payable will be determined as if it were the Secondary Plan. Such payment shall be the limit of EMI Health’s liability, and if the other COB Plan does not provide the information needed by EMI Health to determine its benefits within a reasonable time after it is requested to do so, EMI Health will assume that the benefits of the other plan are identical to this Plan, and will pay its benefits accordingly. However, if within three years of payment, EMI Health receives information as to the actual benefits of the Non-conforming Plan, the Plan will adjust any payments accordingly.
- If the Non-conforming Plan reduces its benefits so that the Covered Person receives less in benefits than he or she would have received had the Plan paid or provided its benefits as the secondary COB Plan and the Non-conforming Plan paid or provided its benefits as the primary COB Plan, then EMI Health shall advance to or on behalf of the Covered Person an amount equal to such difference.
 - In no event will the Plan advance more than it would have paid had it been the primary COB Plan, less any amount it previously paid.

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- In consideration of such advance, the Plan shall be subrogated to all rights of the Covered Person against the Non-conforming Plan in the absence of Subrogation.
 - If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the Primary Plan.

Whenever payments that should have been made under this Plan have been made under any other COB Plan, the Plan Sponsor or EMI Health may, at its own discretion, pay any amounts to the organization that has made excess payments to satisfy the intent of this provision. Amounts paid will be regarded as benefit payment, and the Plan Sponsor and EMI Health will be fully discharged from liability under this Plan to the extent of the payment.

It is important for the Covered Person to take responsibility in reporting to EMI Health any changes in the status of other insurance coverage.

For prompt reimbursement after the payment from the primary insurance carrier, a copy of the itemized billing and a copy of the explanation of benefits provided by the primary insurance carrier must be included.

The amount of medical benefits paid by group, group-type, and individual automobile “no-fault” medical payment contracts are not payable under this Plan. However, when all available no-fault auto medical insurance benefits have been paid, this Plan will pay according to its normal schedule of benefits. If the Covered Person does not have proper no-fault insurance and is involved in an Accident, no benefits will be paid under this Plan until the minimum no-fault auto medical benefits have been paid by the Covered Person, his Dependent, or a third party.

Certain facts may be needed in order to apply COB rules. These facts may be obtained from, or provided to, any other organization or person, subject to applicable privacy laws. Each person claiming benefits under this Plan will be required to give the Plan Sponsor and EMI Health any facts needed to pay a claim.

CLAIMS PROCEDURE

Proof of Loss

Except as otherwise provided in this policy or by Utah law, no benefits provided under this policy shall be paid to, or on behalf of, a Covered Person unless the Covered Person, or his authorized representative, has first submitted a written or Electronic Data Interchange (EDI) claim for benefits to EMI Health. Claims may be submitted at any time within 12 months of the date the expenses are incurred. If, however, the Covered Person shows that it was not reasonably possible to submit the claim within that time period, then a claim may be submitted as soon as reasonably possible. EMI Health may deny an untimely claim.

How to File a Claim

Submit properly completed and coded Provider bills to the following address:

EMI HEALTH
5101 South Commerce Drive
Murray, Utah 84107

If the claim form is not properly completed, it cannot be processed, and it will be returned.

Requests for Additional Information

There are times when claims submitted in the Covered Person's behalf may not contain sufficient information for EMI Health to process them correctly. In those situations, EMI Health will request additional information from the Covered Person or the Provider. EMI Health is likely to request information directly from the Covered Person for the following reasons:

- To obtain details of an Accident
- To expedite coordination of benefits
- To conduct an audit

Covered Persons can expedite the processing of their claims by providing the requested information as quickly as possible, and in as much detail as possible.

Claims Audits

In addition to the Plan's dental record review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed Eligible Expenses and/or are not Medically Necessary and reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of Eligible Expenses or other applicable provisions, as outlined in this Plan Document.

Despite the existence of agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accordance with the terms of this Plan Document.

Non U.S. Providers

Dental expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a “Non U.S. Provider”) are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a Non U.S. Provider;
- The Participant is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
- The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English and include a complete description of the services rendered.

Exhaustion of Administrative Remedies

No action at law or in equity may be brought against EMI Health or the plan administrator, and no arbitration request may be made, until the Covered Person has exhausted the Claims Review Process, as provided in this Plan.

Appointment of Authorized Representative

The Covered Person may appoint an authorized representative to act on his behalf in pursuing a benefit claim or appealing an adverse benefit determination. The Covered Person shall appoint the authorized representative by signing an “Appointment of Authorized Representative” form available from EMI Health, with the authorized representative accepting such appointment by signing the “Appointment of Authorized Representative” form. The Covered Person desiring to appoint an authorized representative shall submit the fully executed form to the plan administrator.

Claims Review Process

For and on behalf of Plan Sponsor, EMI Health will administer the following claims appeal process:

1. If a claim is denied, in whole or in part, a written notice (the “Denial Notice”) will be sent to the Covered Person within (a) 30 days after receiving the initial claim, or (b) 45 days after receiving the claim if EMI Health determines that such an extension is necessary due to matters beyond the control of the Plan and if EMI Health provides an extension notice during the initial 30-day period. If the extension is due to the Covered Person’s

failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent until the date on which the Covered Person responds. The Covered Person has 45 days after receiving the extension notice to complete the claim. The denial notice will set forth the following:

- The specific reasons the claim was denied.
 - Specific references to the pertinent plan provision on which the denial is based.
 - A description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed.
 - An explanation of the Plan's claims review procedure.
2. The Covered Person may appeal an adverse claim decision, in whole or part, by sending a written notice to the EMI Health Claims Review Committee (the "CRC") which will review the initial adverse claim decision on behalf of the Plan Sponsor. This written appeal notice (the "Initial Appeal Notice") must be received by the CRC within 180 days after the date the Covered Person received the Denial Notice. The initial appeal notice must include all pertinent information regarding the claim and must explain the reasons why the Covered Person believes the claim should have been granted, in whole or part. The CRC will then review the initial adverse claim decision on behalf of the Plan Sponsor and shall inform the Covered Person in writing of its decision within 30 days of receipt of the written appeal. The Plan Sponsor will indemnify and hold the CRC harmless with respect to any such decision on appeal, except for intentional acts of the CRC which are clearly made in willful disregard of the rights of the Covered Person. A denial of a claim based on a reasonable interpretation of the provisions of the Plan shall not be considered to be an intentional act which is in willful disregard of the rights of a Covered Person.
 3. If the Covered Person does not agree with the findings of the CRC, the Covered Person may further appeal any adverse claim decision, by sending a second written notice (the "Second Appeal Notice") to the Plan Sponsor, Utah State University - College of Eastern Utah, Attention: Insurance Benefit Department. The second appeal notice must be received within 60 days after the date of the CRC decision. The second appeal notice should include all pertinent information regarding the claim and explain the reasons the Covered Person believes the claim should have been granted, in whole or part. The Plan Sponsor will then review the initial adverse claim decision and also the findings and decision of the CRC. The Plan Sponsor's review and subsequent decision on such second appeal shall be based upon the provisions of the Plan documents in which the Covered Person was enrolled on the date of service of the claim(s) which is (are) subject to such second appeal. The Plan Sponsor will inform the Covered Person in writing of its decision on such second appeal within 30 days of receipt of the second appeal.
 4. If the Covered Person does not agree with the findings of the Plan Sponsor and desires further review the Covered Person shall have a right to submit the matter to binding arbitration or to pursue any remedies available at law or equity or other legal remedy. The Covered Person must submit a written demand for arbitration within 180 days after the Covered Person receives notice of the adverse findings of the Plan Sponsor on the second appeal. Such arbitration will be conducted according to the Utah Arbitration Act. Venue for any court action to enforce an arbitration award or otherwise related to any

claim for benefits shall be exclusively in Salt Lake County, State of Utah. The Plan Sponsor shall bear the costs of arbitration, filing fees, administrative fees, and arbitrator fees. Other expenses of arbitration including, but not limited to, attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses will be borne by the party incurring those expenses. The arbitration award shall not include attorney's fees.

5. The Plan Sponsor shall have the exclusive right to interpret the terms of the Plan. The decision about whether to pay any claim of the Covered Person, in whole or in part, is within the sole discretion of the Plan Sponsor and such decision shall be final and conclusive.
6. The Covered Person shall have the burden of persuasion. He or she will have the right to examine all evidence presented to the CRC and to the Plan Sponsor *and to question witnesses*. It shall be in the discretion of the Plan Sponsor to decide whether to have a hearing on the appeal of the Covered Person. If a hearing is held, it shall be brief and informal, and shall not be conducted according to technical judicial rules of evidence. Rather, any relevant information may be submitted if, in the discretion of the Plan Sponsor, it is evidence upon which responsible persons generally rely.

Independent Review of Medical Necessity

If after exhaustion of the claims review process provided in this Plan, the Covered Person still disputes a determination of Medical Necessity, the Covered Person shall have the voluntary option to submit the adverse benefit determination of Medical Necessity for an independent review.

The independent review shall be conducted by an independent review organization, person, or entity (the "IRO") other than EMI Health, the Plan, the Plan's fiduciary, the Plan Sponsor, or any employee or agent of any of the foregoing, that does not have any material, professional, familial, or financial conflict of interest with EMI Health, any officer, director, or management employee of EMI Health, the Covered Person, the Covered Person's health care Provider, the Provider's medical group or an independent practice association, the health care facility where service would be provided, or the developer or manufacturer of the service being provided.

EMI Health will select the IRO, which shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health insurance plan, a national, state, or local trade association of health insurance plans, or a national, state, or local trade association of health care Providers.

The Covered Person may initiate such independent review of Medical Necessity by giving written notice to EMI Health of the Covered Person's election to proceed with independent review within 180 days from the date of the receipt, in writing, from EMI Health of the final adverse benefit determination of Medical Necessity from the claims review process.

If the Covered Person timely elects the above independent review, then EMI Health will inform the Covered Person, in writing, of the decision of the IRO, within 60 days after the date EMI Health received the Covered Person's written request for independent review of Medical Necessity.

Subrogation and Reimbursement

When EMI Health, on behalf of Plan Sponsor, has advanced payment of benefits to or on behalf of a Covered Person for any bodily injury actionable at law or for which the Covered Person may obtain a recovery from a third party, or any other responsible insurance, the Plan acquires a right of Subrogation against the third party or other responsible insurance, and a right of reimbursement against the Covered Person. In such situations, the Covered Person has the following obligations:

- The Covered Person must reimburse the Plan, up to the amount of such benefits advanced or paid by the Plan, as follows: (a) out of any recovery obtained by the Covered Person from the third party (or such party's liability insurance) by judgment, settlement, or otherwise, whether or not the Covered Person is or has been made whole. The Plan is entitled to the first dollar of any recovery by the Covered Person and each dollar thereafter up to the amount of benefits advanced or paid by the Plan for the injuries to the Covered Person that were caused by the third party; and (b) out of any recovery obtained by the Covered Person from his or her underinsured or uninsured motorist coverage provided the Covered Person has been made whole. The Covered Person shall do nothing to prejudice the rights of the Plan.
- The Covered Person cannot limit or avoid such reimbursement obligation to the Plan by any agreement with the third party or any assignment or designation of such proceeds.
- The Covered Person must not release or discharge any claims that the Covered Person may have against any potentially responsible parties or insurance without written permission from the Plan.
- The Covered Person must fully cooperate and assist with the Plan Sponsor and EMI Health (including, but not limited to, executing all required instruments and papers), if the Plan chooses to pursue its own right of Subrogation against the third party; the Plan's right of Subrogation is limited to the amount of benefits advanced or paid by the Plan to or on behalf of the Covered Person as a result of the fault of the third party, and the Plan's right to recover such benefits from the third party does not depend upon whether the Covered Person is made whole by any recovery. This right of reimbursement shall remain in effect until the Plan is repaid in full. The Plan Sponsor and EMI Health may also pursue their right of Subrogation against any other responsible insurance of the Covered Person provided the Covered Person has been made whole.

The benefits under this Plan are secondary to any coverage under no-fault or similar coverage.

The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment, or other payment intended for, payable to, or received by the Covered Person, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the Plan secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Covered Person agrees to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100 percent of all benefits paid on behalf of the Covered Person.

By accepting benefits hereunder, the Covered Person, hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Covered Person. This assignment is binding on any attorney who represents the Covered Person, whether or not the Covered Person's agent, and on any insurance company or other financially responsible party against whom the Covered Person may have a claim provided said attorney, insurance carriers, or others have been notified by the Plan or its agents.

In the event the Covered Person fails to reimburse the Plan for advanced payment of benefits as provided for in this section, then in addition to reimbursement to the Plan of the advanced payment(s) the Covered Person shall be responsible for all fees and expenses, including but not limited to collection costs, court costs, litigation expenses, arbitration expenses, and attorney's fees, incurred by EMI Health and/or the Plan Sponsor for collecting the advanced payment(s).

Right of Recovery

The Plan will have the right to recover any payment made in excess of the Plan's obligations. Such recoveries must be initiated within 12 months (or 24 months for a COB claim) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by the Covered Person. This right of recovery applies to payments made to the covered Person or to the Provider. If such overpayment is made to the Covered Person, he or she must promptly refund the amount of the excess. If the overpayment is made to a Provider, and attempts to recover overpayments from said Provider are exhausted, the Covered Person may be responsible for reimbursement to the Plan. The Plan may, at its sole discretion, offset any future benefits against any overpayment.

Benefit Accumulations

All Deductibles, benefit limits, etc., except for the Lifetime Maximum Benefit, accumulate on a Contract Year basis.

DEFINITION OF TERMS

Accident and Accidental Injury, for which benefits are provided, means Accidental bodily Injury sustained by the Covered Person which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause.

Act of Aggression means any physical contact initiated by the Covered Person that a reasonable person would perceive to be a threat of bodily harm.

Actively at Work or Active Work means being in attendance at the customary place of employment, performing the duties of employment on a Full-time Basis, and devoting full efforts and energies in the employment.

Adverse Benefit Determination means any of the following:

1. A denial in benefits,
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure.

Allowable Expenses, when used in conjunction with Coordination of Benefits, shall have the same meaning as the term “Allowable Expenses” in U.A.C. Rule R590-131-3.A.

Anterior means the teeth and tissues located towards the front of the mouth; maxillary and mandibular incisors and canines.

Calendar Year means the 12-month period beginning January 1 and ending December 31.

CHIP refers to the Children’s Health Insurance Program or any provision or section thereof, which herein specifically referred to as such act, provision, or section may be amended from time to time.

COB Plan means a form of coverage with which Coordination of Benefits is allowed. These COB Plans include the following:

- Individual, and group accident and health insurance contracts and subscriber contracts, except those included in the following paragraph
- Uninsured arrangements of group or group-type coverage
- Coverage through closed panel plans
- Medical care components of long-term care contracts, such as skilled nursing care
- Group-type contracts
- Medicare or other governmental benefits, as permitted by law

The term COB Plan does not include any of the following:

- Hospital indemnity coverage benefits or other fixed indemnity coverage
- Accident-only coverage

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- Specified disease or specified Accident policies
 - Limited benefit health coverage, as defined in U.A.C. Rule R590-126
 - School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis
 - Benefits provided in long-term care insurance policies for non-medical services
 - Any state plan under Medicaid
 - A government plan, which by law provides benefits that are in excess of those of any private insurance or other non-governmental plan
 - Medicare supplement policies

The term COB Plan is construed separately with respect to each policy, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a policy, contract, or other arrangement which is subject to a Coordination of Benefits provision, as separate from the portion which is not subject to such a provision.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Administrator is Educators Mutual Insurance Association. **Coinsurance** means the percentage of eligible charges payable by a Covered Person directly to a Provider for covered services. Coinsurance percentages are specified on the “Schedule of Benefits” chart.

Conforming Plan means a COB Plan that is subject to U.A.C. Rule R590-131.

Contract Year means the 12-month period following the effective date of this policy and any 12-month period following that date.

Coordination of Benefits means a provision establishing an order in which plans pay their Coordination of Benefits claims, and permitting Secondary Plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.

Copayment or **Copay** means, other than coinsurance, a fixed dollar amount that a Covered Person is responsible to pay directly to a Provider. Copayment amounts are specified on the “Schedule of Benefits” chart.

Cosmetic Treatment means any procedure performed to improve appearance or correct a congenital deformity that does not affect function.

Covered Person means an eligible person who enrolled with EMI Health through the Employer’s group to receive covered services and who is recognized by EMI Health as a Covered Person. Employees/retirees of the Employer who are eligible to become Covered Persons can choose to enroll Dependents who satisfy EMI Health’s Dependent eligibility requirements. In situations requiring consent, payment, or some other action, references to “Covered Person” include the parent or guardian of a minor or disabled Covered Person on behalf of that Covered Person.

Deciduous means having the property of falling off or shedding; a name used for the primary teeth.

Deductible means the amount paid by a Covered Person for Eligible Expenses from the Covered Person’s own money before any benefits will be paid under this policy.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time, and in the place, services are performed.

Dependent means the Participant's children (including stepchildren, legally adopted children, and children for whom the Participant has legal guardianship) to their 26th birthday. A child is considered a Dependent beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is dependent on the Participant for support and maintenance. The Participant must furnish proof of disability and dependency to EMI Health within 31 days after the child reaches 26 years of age. EMI Health may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. Dependent also refers to any of the Participant's natural children, children legally placed for adoption, or adopted children for whom a court order or administrative order has dictated that the Participant provide coverage. Dependent also refers to the Participant's Spouse. Dependent does not include an unborn fetus.

Eligible Expenses means those charges incurred by the Covered Person for illness or injury that meet all of the following conditions:

- Are necessary for care and treatment and are recommended by a Provider while under the Provider's continuous care and regular attendance.
- When more than one treatment option is available, and one option is no more effective than another, the Eligible Expenses shall be for the least costly option that is no less effective than any other option.
- Do not exceed the EMI Health Schedule of Benefits and the Maximum Allowable Charge for the services performed or materials furnished.
- Are not excluded from coverage by the terms of this Plan.
- Are incurred during the time the Covered Person is covered by this Plan.

EMI Health means Educators Mutual Insurance Association.

Employee means a Full-time Employee or an elected or appointed officer of the Plan Sponsor. Employees must be legally entitled to work in the United States.

Employer means Plan Sponsor.

Enrollment Date means the first day of coverage, or if there is a waiting period before coverage takes effect, the first day of the waiting period.

Exclusion means the policy does not provide insurance coverage, for any reason, for one of the following:

- A specific physical condition;
- A specific medical procedure;
- A specific disease or disorder; or
- A specific prescription drug or class of prescription drugs.

Experimental or Investigative means a drug, device, medical treatment, or procedure that meets any of the following conditions:

- These Experimental or Investigative methods are not yet accepted as an approved or standard of care diagnosis or treatment by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, the Utah Medical Association, or Reliable Evidence.

- Reliable Evidence includes published reports and articles in authoritative medical and scientific literature, the written protocol(s) used by the treating facility, the protocol(s) of another recognized and authoritative facility, or the prevailing opinion among medical experts in the field.

Former Employee means an Employee who has retired or terminated employment and who is eligible for continuation of coverage.

Full-time Basis or **Full-time Employment** means an Active Employee of the Employer; an Employee is considered to be Full-time if he or she normally works at least the number of hours per week designated by the Employer and is on the regular payroll of the Employer for that work.

Grace Period means the period that shall be granted for the payment of any policy charge, during which time the policy shall continue in force. In no event shall the Grace Period extend beyond the date the policy terminates.

He or **Him** includes and means she or her.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Leave of Absence means a leave of absence of an Employee that has been approved by the Employer, as provided for in the Employer's rules, policies, procedures, and practices.

Lifetime Maximum Benefit means the maximum amount of benefits paid by EMI Health that will be allowed under this Plan whether accumulated under this policy or any combination of policies administered by EMI Health. If this Plan covers orthodontic services, amounts paid under a previous dental care plan, whether administered by EMI Health or any other carrier, for orthodontic benefits will be deducted from the maximum payable for orthodontic benefits under this Plan.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of the Table of Allowances or the actual billed charges for the covered services. The Maximum Allowable Charge will not include payment for any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary or **Medical Necessity** means any health care service, supply, or accommodation the Provider renders for the treatment of Illness or injury that meets all of the following conditions:

- Consistent with the symptoms or diagnosis.
- Provided in the most cost-effective setting that can be used safely.

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- Not for the convenience of a Covered Person, physician, Hospital, or other Provider.
 - Appropriate with regard to standards of good medical practice in the community and could not be omitted without adversely affecting the condition or quality of medical care, as determined by established medical review.
 - Within the scope of the Provider's licensure.
 - Consistent with, and included in, procedures established and recognized by EMI Health or a designated representative.

Participant means the individual employed by the Plan Sponsor and enrolled with the Plan to receive covered services, through whom Dependents may also be enrolled with the Plan. Participants are also Covered Persons. The term Participant may include eligible early retirees. An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Program as defined by the Employer's policy and is approved by his or her respective administration for early retirement, may have dental insurance continue from the time of his or her early retirement until the end of the month in which he or she reaches age 65.

Participating Provider means a health care practitioner operating within the scope of his license, i.e., physician, oral surgeon, Dentist, anesthetist, etc., or a facility operating within the scope of its license, who has contracted with the Plan to render covered services and who has otherwise met the criteria and requirements for participation in the Plan.

Plan Sponsor means Utah State University Eastern.

Premium Assistance means assistance under Utah Code Title 26, Chapter 18, Medical Assistance Act, in the payment of premium.

Primary Plan means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration.

Provider means a health care practitioner operating within the scope of his license, i.e., physician, oral surgeon, Dentist, chiropractor, anesthetist, etc. Provider also means a facility operating within the scope of its license.

Secondary Medical Condition means a complication related to an Exclusion from coverage in the Plan.

Secondary Plan means any plan that is not a Primary Plan.

Special Enrollment means the right of an individual to enroll during the plan year, rather than waiting for the next Open Enrollment period, if He has experienced a qualifying event (including marriage, divorce, birth, adoption, placement for adoption, loss of other insurance coverage, or approval to receive a Premium Assistance) under HIPAA or ERISA regulations. The Participant must complete a new enrollment form and submit it to EMI Health within 30 days of any change in coverage or status.

Spouse means the person to whom the Participant is lawfully married or the person to whom the Participant is lawfully recognized as a common law Spouse.

Subrogation means the right that the Plan has by virtue of this contract, and also by virtue of common law, to recover from a third party or other responsible insurance, monies that the Plan has advanced or paid to or on behalf of a Covered Person, where such monies were paid as a result of an injury to the Covered Person that was the fault of the third party.

Summary of Benefits means the outline of benefits as established by this policy.

Table of Allowances means the schedule for payment of covered services established by EMI Health.