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## INTRODUCTION

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We welcome you as a member of the EMI Health family and look forward to serving your insurance needs!

Southern Utah University's health and dental benefits and EMI Health's administrative procedures are described in this handbook. **Receipt of this handbook does not guarantee coverage under all Plans. You are only covered by those Plans in which you enrolled.** You are urged to read your handbook carefully, share its contents with the members of your family, and keep it for future reference. If you have any questions or need further information, contact your employer or the EMI Health Customer Service Department.

Notwithstanding anything else in the Plans to the contrary, the items listed in the "Plan Exclusion" sections are not covered by the Plans.

Regardless of benefits specified, the Plans will reimburse or pay any claim only if the services rendered are determined to be medically necessary. Determination of Medical Necessity is made by EMI Health using its own set of criteria, or by an independent contractor appointed by EMI Health.

This is your plan. Anything you can do to contain costs will help provide additional benefits in the future. We recommend doing the following to assist in the reduction and control of costs:

- Question the need for medical services and physician visits.
- Reduce the length of hospital confinements where possible.
- Be sure all charges are for services actually provided.
- Ask about the price; charges should be competitive.

If you need more information on any of the Southern Utah University health and dental benefits, or on EMI Health's procedures, please call a Customer Service Representative between 8:00 a.m. and 5:00 p.m., Monday through Friday (MT):

(801) 262-7475 in Salt Lake City or  
(800) 662-5851 elsewhere in the Continental U.S.A.

### **Plan Administrator**

These EMI Health plans are administered by Educators Mutual Insurance Association of Utah.

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Administered by Educators Health Plans Life, Accident, and Health  
 EMI Health Customer Service 801-270-2880 or 1-800-662-5851  
 Self Funded Employee Medical Benefit Plan

All services are subject to the EMI Health Table of Allowances. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Table of Allowances.		
Southern Utah University #144 351 W. University Blvd., Cedar City, Utah 84720 435-586-7754	Care Plus	
July 01, 2014 - June 30, 2015 Option 1 - \$1,000 Ded	Participating Provider Option	Non-Participating Provider Option
<b>GENERAL INFORMATION</b>	<b>YOU PAY</b>	
Preexisting Condition Window Period	None	
Preexisting Condition Waiting Period	None	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Coinsurance Maximum (Per Person/Family Per Year). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	\$3,000 / \$6,000	\$6,000 / \$12,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Prescription Drug Deductible). Please note ♦	\$1,000 / \$2,000	\$2,000 / \$4,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
<b>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) - administered by VRx</b>	<b>YOU PAY</b>	
Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical Deductible). Please note ●.	\$50 / \$150	
Participating Pharmacy (30 day supply)	●Generic - \$10 ●Preferred - 30% (\$250 Max) ●Non-Preferred - 50% (\$350 Max)	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	●Generic - \$20 ●Preferred - 30% (\$250 Max) ●Non-Preferred - 50% (\$350 Max)	
Specialty Drug	● Tier 1 - 15% (\$200 Max) ● Tier 2 - 25% (\$275 Max) ● Tier 3 - 40% (\$400 Max) ● Tier 4 - Excluded Prescriptions	
<b>PREVENTIVE SERVICES</b>	<b>YOU PAY</b>	
Routine Physical Exam (1 visit per Year)	Covered 100%	♦40%
Routine Gynecological Exam (1 visit per Year)	Covered 100%	♦40%
Family History Exam (1 visit per Year)	Covered 100%	♦40%
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	♦40%
Routine Well-Baby Exams	Covered 100%	♦40%
Covered Immunizations	Covered 100%	♦40%
Routine Vision Exam (1 visit per Year)	Covered 100%	♦40%
Routine Hearing Exam (1 visit per Year)	Covered 100%	♦40%
<b>PHYSICIAN &amp; PROFESSIONAL SERVICES</b>	<b>YOU PAY</b>	
Physician Office Visits (primary care)	\$40	♦40%
Physician Office Visits (secondary care)	\$50	♦40%
Physician Office Visits (after hours)	\$50	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (office)	20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦20%	♦40%
Radiology/Pathology (office)	20%	♦40%
Radiology/Pathology (Inpatient)	♦20%	♦40%
Radiology/Pathology (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 Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%

Southern Utah University #144 351 W. University Blvd. , Cedar City, Utah 84720 435-586-7754	Care Plus	
July 01, 2014 - June 30, 2015 Option 1 - \$1,000 Ded	Participating Provider Option	Non-Participating Provider Option
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 30 visits per Year)	\$50	◆40%
Chiropractic Therapy (10 visits per Year)	\$50	◆40%
Allergy Testing	20%	◆40%
Allergy Treatment/Serum	20%	◆40%
<b>HOSPITAL/FACILITY BENEFITS</b> (Physician & Professional Services are not included in this section.)	<b>YOU PAY</b>	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆20%	◆40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆20%	◆40%
Skilled Nursing Facility (60 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	◆20%	◆40%
Medical/Surgical Care (Outpatient)	◆20%	◆40%
Emergency Room (ER)	\$300	\$300
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	◆20%	◆40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆20%	◆40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	◆20%	◆40%
Newborn	20%	40%
InstaCare/Urgent Care Clinic	\$50	◆40%
Eligible Preventive Services	Covered 100%	Not Covered
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (30 days per person per Year)	◆20%	◆40%
<b>ACCIDENT AND LIFE THREATENING CONDITION</b>	<b>YOU PAY</b>	
Supplemental Accident/Life-Threatening Illness Benefit	Covered 100% for first \$1000 per Year then regular benefits apply	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	
Ambulance Land/Air (Accident & Life-threatening)	◆20%	Covered as a Participating Benefit subject to the Table of Allowance
Orthodontic Injury Treatment	◆50%	
Dental Injury Treatment	◆20%	
<b>TRANSPLANT BENEFIT</b>	<b>YOU PAY</b>	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
<b>MEDICAL SUPPLIES &amp; EQUIPMENT</b>	<b>YOU PAY</b>	
Diabetic Testing Supplies (90 day supply)	30%	◆40%
Medical Supplies	◆20%	◆40%
Medical Supplies (office)	Covered 100%	
Durable Medical Equipment	◆20%	◆40%
Orthotic Supplies	◆20%	◆40%
Growth Hormone	◆20%	◆40%
<b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>	<b>YOU PAY</b>	
Inpatient Facility Semi-private Room	◆20%	◆40%
Inpatient Facility Ancillary	◆20%	◆40%
Inpatient Facility Physician Visits	◆20%	◆40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	\$50	◆40%
<b>ADDITIONAL BENEFITS</b>	<b>YOU PAY</b>	
Adoption Indemnity Benefit	The Plan pays a maximum of \$4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment	◆*50%	Not Covered
Orthognathic/Mandibular Osteotomy	◆*50%	Not Covered
Total Parenteral Nutrition (TPN)	◆*50%	Not Covered
Primary Infertility	◆*50%	Not Covered
Reduction Mammoplasty	◆*50%	Not Covered

PLEASE NOTE: This is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan document and in the Summary Plan Description (SPD)/handbook of the Plan. Any discrepancies between this summary, the SPD/handbook, and the Plan document are resolved in favor of the Plan document. For more information, including Preauthorization, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.

Services designated ● are subject to first dollar Prescription Drug Deductible.  
Services designated ◆ are subject to first dollar Medical Deductible  
Services designated \* do not accumulate toward the applicable Coinsurance Maximum.



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<b>Southern Utah University #144</b> 351 W. University Blvd. , Cedar City, Utah 84720 435-586-7754	<b>Care Plus</b>	
July 01, 2014 - June 30, 2015 Option 2 - \$1,500 Ded	<b>Participating Provider Option</b>	<b>Non-Participating Provider Option</b>
<b>GENERAL INFORMATION</b>	<b>YOU PAY</b>	
Preexisting Condition Window Period	None	
Preexisting Condition Waiting Period	None	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Coinsurance Maximum (Per Single/Family Per Year)	\$3,000 / \$6,000	\$6,000 / \$12,000
Medical Deductible (Per Single/Family Per Year). Please note ♦	\$1,500 / \$3,000	\$3,000 / \$6,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
<b>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) - administered by VRx</b>	<b>YOU PAY</b>	
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Allergy Treatment/Serum	◆20%	◆40%
<b>HOSPITAL/FACILITY BENEFITS</b> (Physician & Professional Services are not included in this section.)	<b>YOU PAY</b>	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆20%	◆40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆20%	◆40%
Skilled Nursing Facility (60 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	◆20%	◆40%
Medical/Surgical Care (Outpatient)	◆20%	◆40%
Emergency Room (ER)	◆20%	◆20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	◆20%	◆40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	◆20%	◆40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	◆20%	◆40%
Newborn	◆20%	◆40%
InstaCare/Urgent Care Clinic	◆20%	◆40%
Eligible Preventive Services	Covered 100%	Not Covered
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (30 days per person per Year)	◆20%	◆40%
<b>ACCIDENT AND LIFE THREATENING CONDITION</b>	<b>YOU PAY</b>	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit subject to the Table of Allowance
Ambulance Land/Air (Accident & Life-threatening)	◆20%	
Orthodontic Injury Treatment	◆20%	
Dental Injury Treatment	◆20%	
<b>TRANSPLANT BENEFIT</b>	<b>YOU PAY</b>	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
<b>MEDICAL SUPPLIES &amp; EQUIPMENT</b>	<b>YOU PAY</b>	
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Medical Supplies (office)	◆20%	◆40%
Durable Medical Equipment	◆20%	◆40%
Orthotic Supplies	◆20%	◆40%
Growth Hormone	◆20%	◆40%
<b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>	<b>YOU PAY</b>	
Inpatient Facility Semi-private Room	◆20%	◆40%
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Services designated ◆ are subject to first dollar Medical Deductible  
Services designated \* do not accumulate toward the applicable Coinsurance Maximum.



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## GENERAL PLAN INFORMATION

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SOUTHERN UTAH UNIVERSITY 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, 2014, and is also the formal plan document for the Plan.

Please note that capitalized terms used in this document are defined either the first time they are used or in the “Definitions 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. The Plan Sponsor has purchased a stop loss insurance policy from Educators Mutual Insurance Association of Utah which will provide coverage to the Plan Sponsor in the event individual and aggregate claims exceed a certain level, but Educators Mutual Insurance Association of Utah does not insure any benefits under the Plan.

### TYPE OF ADMINISTRATION

The Plan Sponsor is the Plan Administrator. The Plan Sponsor has entered into an agreement with Educators Mutual Insurance Association of Utah (“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 SOUTHERN UTAH UNIVERSITY SELF-FUNDED EMPLOYEE MEDICAL BENEFIT PLAN (CARE PLUS)**

**GROUP NUMBER: 144**

**EFFECTIVE DATE OF PLAN AS AMENDED AND RESTATED: July 1, 2014**

**PLAN YEAR ENDS: June 30, 2015**

### EMPLOYER/PLAN SPONSOR INFORMATION

Southern Utah University  
Director of Human Resources  
351 W. University Blvd.  
Cedar City, Utah 84720  
Telephone: (435) 586-7754  
Fax: (435) 586-7948

### PLAN ADMINISTRATOR

Southern Utah University  
Director of Human Resources  
351 W. University Blvd.  
Cedar City, Utah 84720  
Telephone: (435) 586-7754  
Fax: (435) 586-7948

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## **NAMED FIDUCIARY**

Southern Utah University  
Director of Human Resources  
351 W. University Blvd.  
Cedar City, Utah 84720  
Telephone: (435) 586-7754  
Fax: (435) 586-7948

## **AGENT FOR SERVICE OF LEGAL PROCESS**

Southern Utah University  
Director of Human Resources  
351 W. University Blvd.  
Cedar City, Utah 84720  
Telephone: (435) 586-7754  
Fax: (435) 586-7948

## **CLAIMS ADMINISTRATOR**

EMI Health  
852 East Arrowhead Lane  
Murray, Utah 84107-5298  
Telephone: (801) 262-7476  
Fax: (801) 269-9734  
Website: [www.emihealth.com](http://www.emihealth.com)

## **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 an 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

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not be deemed to modify the provisions 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.

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## ELIGIBILITY AND PARTICIPATION

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### Eligibility

An Employee of the Plan Sponsor and his Dependents are eligible for participation and coverage under this Plan if the Employee is a benefit eligible Employee of the Plan Sponsor. Dependents of the Employee eligible for coverage include Dependent children from birth to the 26<sup>th</sup> birthday and the Employee's legal 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.

Children may include foster children if all of the following conditions are met:

- The child lives with the Employee;
- The parent-child relationship is with the Employee, not solely the child's biological parent;
- The Employee is the primary source of financial support for the child; and
- The Employee expects to raise the child to adulthood.

A Dependent child's coverage may be extended beyond the 26<sup>th</sup> 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 the Plan Sponsor and Claims Administrator within 31 days after the child reaches 26 years of age. The Claims Administrator 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 the Plan Sponsor 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 31 days of his employment, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such 31-day period) becomes effective on the date of hire.

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If the Employee enrolls during a subsequent 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 31 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

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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, the last day of the calendar month coinciding with or following the Participant's termination of employment or when the Participant's employment position or status changes such that He is no longer a Full-time Employee, unless specific provisions in the Employer's policy manual apply.
- For the Participant and covered Dependents, the last day of the month for which coverage has been paid, subject to a 31-day Grace Period in the event any required Participant contributions are not made;
- 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 26<sup>th</sup> 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 provision or amendment resulting in loss of eligibility;
- For the Participant and covered Dependents, the date this Plan is terminated; or
- For any Covered Person, the discovery of fraud or misrepresentation on the part of the Covered Person in either the enrollment process or in the use of services or facilities,

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including any misuse of a Plan ID card. (Note: If a Covered Person's coverage is terminated for cause, the termination of coverage will relate back to the effective date of coverage (after a 30 day advance notice) and the Plan Sponsor may recover any overpayments from the Covered Person such that the Plan Sponsor and the Covered Person are returned to the same financial position as if no coverage had ever been in force. Termination of a Participant's coverage for cause will also result in the termination of coverage of the Participant's covered Dependents.) Employment may be terminated for health care fraud. The termination will be considered for "gross misconduct," and COBRA will not be offered to the Employee, former Employee, or any other qualified beneficiaries.

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 31 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 He continues to pay any required Employee portion of the cost of coverage in accordance with the Plan Sponsor's FMLA leave policy. The Plan Sponsor will continue to make the same contributions toward that coverage that it would have made had the Participant not taken FMLA leave.
- If the Employee portion of the cost of coverage is 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 immediately following the expiration of the FMLA leave. If the Participant does not return to work before or immediately 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, the Plan Sponsor 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.

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### **Qualified Medical Child Support Orders**

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

### **Benefits for Employees Working Beyond Age 65**

If a Participant becomes eligible for Medicare solely as a result of attaining age 65, the Participant will have the option of electing coverage under this Plan, in which case this Plan is primary and Medicare is secondary. Alternatively, the Participant may elect to terminate coverage under this Plan and choose Medicare as his primary coverage. If a Participant chooses Medicare as his primary plan, the Participant may not elect this Plan as his secondary plan. If the Participant elects to terminate coverage under this Plan, coverage will also be terminated for his Dependents.

Contact the Plan Sponsor or the EMI Health Enrollment Department for information.



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## CARE PLUS MEDICAL PLAN BENEFITS

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### Using the Care Plus Benefits

Covered Persons should always carry their EMI Health Care Plus Medical Identification Cards so that Participating Providers can determine what the Covered Person is required to pay, how to bill the Plan, and when to preauthorize major services.

- Covered Persons generally should go to an EMI Health Care Plus primary care physician (PCP) first. EMI Health Care Plus PCPs are specialists in family practice, internal medicine, pediatrics, and obstetrics or gynecology. PCPs provide primary care and can help coordinate secondary Provider care. If the Covered Person chooses to see a secondary care or ancillary care participating physician, He will pay a higher Copayment. A directory of Participating Providers will be furnished free of charge as a separate document. The Covered Person may also obtain a copy of the directory of Participating Providers from the Plan Sponsor, on the Internet at [www.emihealth.com](http://www.emihealth.com) or by calling 801-262-7475.
- The EMI Health Care Plus Plan provides the following levels of care:
  1. Covered Persons are eligible for Participating Provider Option benefits when receiving care from Participating Providers.
  2. Covered Persons may choose to receive care from Non-participating Providers. However, when a Covered Person receives care from a Non-participating Provider, benefits are determined based on the Non-participating Provider Option (see “Summary of Benefits” chart). These benefits are less than the corresponding benefits under the Participating Provider Option.

Although benefits under the Plan are generally greater for services provided by Participating Providers, the choice to use a Participating Provider or Non-participating Provider is entirely up to the Covered Person. EMI Health does not employ Participating Providers, and they are not agents or partners of EMI Health. Providers participate in the network only as independent contractors. Participating Provider status is not an endorsement or representation by the Plan Sponsor, Plan Administrator, or EMI Health as to the qualifications (or quality of care) of any particular Provider.

- **Advantages of Using Participating Providers.** When Covered Persons elect to use Participating Providers, they enjoy the following advantages over Non-participating Providers:
  - The Provider bills the Plan for them;
  - The Provider accepts the Plan’s Maximum Allowable Charges and agrees not to bill Covered Persons in excess of the Maximum Allowable Charge for covered services; and
  - The Provider agrees to obtain Preauthorization from the Plan for Covered Persons for major services.
- Covered Persons should verify their Providers’ panel status at the time of each visit by following these steps:
  - Contact Providers to assure that they are Participating Providers with EMI Health.

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- Contact EMI Health Customer Service Department.

The Table of Allowances is the schedule established by EMI Health, on behalf of Plan Sponsor, for payment of eligible charges. **All benefits outlined in this Plan are subject to the Maximum Allowable Charge. For example, if a Provider charges \$125 for a procedure for which the Table of Allowances permits \$100 payment, the Plan will pay the specified percentage of \$100, not \$125.**

### **When Non-participating Provider Option Benefits Apply**

Participating Provider Option benefits are available when the care is provided through a Participating Provider. Non-participating Provider Option benefits offer Covered Persons the flexibility to use any Non-participating Provider or facility.

In cases where the Covered Person uses a participating facility but uses a non-participating physician, Participating Provider Option benefits will apply to services from the participating facility, while Non-participating Provider Option benefits, which may require more payment by the Covered Person, will apply to services rendered by the non-participating physician.

- **Using Non-participating Providers and Facilities.** When the Covered Person elects to use Non-participating Providers and facilities
  - The Covered Person must obtain Preauthorization from the Plan for major services. (Refer to the *Preauthorization Requirements* section.)
  - The benefits may be less, and in some cases, there may be no benefits available under the Non-participating Provider Option.
  - The Covered Person is responsible for any billed charges exceeding the Maximum Allowable Charge for covered services.

Even in the unlikely event that there is no Participating Provider available to perform the services needed, the Plan will not pay Participating Provider Option benefits to a Non-participating Provider. Non-participating Provider Option benefits will apply.

### **Coinsurance Maximum**

The Coinsurance Maximum is designed to insure against financial hardship caused by unexpected expenses from catastrophic illness. When a Covered Person has satisfied any applicable Deductible and paid Eligible Expenses, including eligible Copayments, up to the Coinsurance Maximum, the Plan will pay remaining Eligible Expenses at 100% of the Maximum Allowable Charge.

When a Covered Person receives any service or treatment specified as a limited benefit, the Plan will pay for services only up to the specified amounts.

Any payment made by the Covered Person for amounts in excess of the limits, and expenses the Covered Person pays if He does not follow Preauthorization procedures, will not accumulate toward the annual Deductible or Coinsurance Maximum. The Participating Provider and Non-participating Provider Options each have a separate Coinsurance Maximum.

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## Benefit Accumulations

All Deductibles, Coinsurance Maximums, benefit limits, etc., accumulate on a Plan Year basis, beginning July 1 and ending June 30.

## Care Plus Preauthorization Requirements

“Preauthorization” is the procedure for confirming, prior to the rendering of care, the medical necessity and appropriateness of the proposed treatment, and whether (and if so, to what extent) such treatment is a covered benefit for the Covered Person. Whether Preauthorization is required, and if so, how and when it must be obtained, depends on the kind of treatment and whether the Provider is a Participating Provider or a Non-participating Provider.

- **The following kinds of treatments require Preauthorization:**
  - Hospitalizations and Inpatient facility admissions, including skilled nursing facilities and mental health and drug/alcohol treatment
  - Surgeries, in a Hospital or ambulatory surgical facility (This does not apply to diagnostic endoscopy procedures, appendectomies, or cholecystectomies.)
  - Home Health services, including home I.V. services
  - Dental services, including orthodontics, when dental injury occurs as a result of an Accident
  - Hernia-related procedures
  - Durable Medical Equipment and Prostheses costing more than \$750 (see *Medical Supplies and Equipment*)
  - Hyperbaric oxygen treatment
  - Subcutaneous hormone pellet implantation of testosterone pellets
  - Clinical trials
  
- Pre-notification of Dayspring/Day Treatment is recommended, since some services provided by Dayspring/day treatment facilities are not covered, including but not limited to, convenience items, biofeedback, education, and family therapy.
  
- **If the Covered Person uses a Participating Provider** for any of the above treatments or procedures, **the Provider** (not the Covered Person) is responsible for Preauthorization. **The Covered Person is advised to verify with the physician that Preauthorization procedures have been followed.**
  
- **If the Covered Person uses a Non-participating Provider** for any of the above treatments or procedures, **the Covered Person (even in an emergency) is responsible for obtaining Preauthorization, and benefits may be denied or reduced if the Covered Person fails to timely obtain Preauthorization**, as follows:
  - To obtain Preauthorization for Durable Medical Equipment or Prostheses submit, to EMI Health, a written request accompanied by a letter of Medical Necessity.
  - To obtain Preauthorization for all other services, call 1-801-270-3037 or (toll free) 1-888-223-6866.
  - For services or treatments that require Inpatient hospitalization, other than emergencies, the Covered Person must obtain Preauthorization at least 48 hours prior to receiving the services or treatments.

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- **For emergency hospitalizations, the Covered Person must give notice of the hospitalization within 48 hours of the admission**, or as soon as reasonably possible, by calling one of the phone numbers listed above. An appropriate length of hospitalization will then be determined.
  - If a Covered Person responsible for obtaining Preauthorization fails to do so in the required time, EMI Health will review the treatment and apply the following penalties:
    - If the treatment is deemed not Medically Necessary and appropriate, benefits will be denied.
    - If the treatment is deemed Medically Necessary and appropriate, benefits will be reduced by 50% (per admission for Inpatient hospitalization, or per service or procedure, for the others listed above).
    - Any amount paid out-of-pocket for failing to follow Preauthorization requirements is not applied toward the Coinsurance Maximum.

### **Preauthorization Review Process**

The Covered Person may request a review of any determination of Medical Necessity adverse to the Covered Person, by contacting the Plan's Utilization Review at 1-801-270-3037 or toll free 1-888-223-6866 within 60 days after the Covered Person receives notice of the adverse decision. The Plan's Utilization Review will inform the Covered Person, in writing, of its decision. If the previous decision stands, the Covered Person will be given a specific reason for the decision.

If the Covered Person disagrees with the finding of the Plan's Utilization Review, He may request a second review by calling the Plan's Utilization Review at the phone numbers listed above. This request must be made within 30 days of the date of the letter indicating the decision on the first level appeal. The participants in the second appeal review will not include anyone involved in the first level appeal. The Plan's Utilization Review will inform the Covered Person of its decision, and if adverse to the Covered Person, the basis of its decision.

If, after exhaustion of the Preauthorization Review Process provided in this Plan, the Covered Person still disputes the results of the same, the subject dispute shall be submitted for resolution through Independent Review or binding arbitration. The procedure for Independent Review shall be provided in the *Independent Review* provision of this Plan. The procedure for arbitration shall be as provided in the *Arbitration* provision of this Plan.

No arbitration request may be made until the Covered Person has exhausted the Preauthorization Review Process, as provided in this Plan.

The Covered Person may request a review of any adverse determination based on Plan benefits or eligibility by following the Claims Review Process provided in this Plan.

### **Second Opinion**

In order to determine whether any proposed or continuing care, diagnosis, treatment, service, surgical procedure, diagnostic or medical procedure, drug therapy, blood transfusion, or other covered service (collectively the "Recommended Care") is Medically Necessary and appropriate, the Plan may, at any time, require at its own expense a Covered Person to obtain a second (and third, if necessary) opinion from a Participating Provider, selected by the Plan, regarding such recommended care.

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### **Inform EMI Health of Changes**

The Participant may call EMI Health Enrollment Department or submit an Enrollment Application to notify the Plan of a change in his address or telephone number. The Participant must use the Enrollment Application to make other changes, such as changes to name and/or marital status, as well as to add or delete family members to the Plan. Enrollment Applications are submitted to the Plan Sponsor. (See the *Eligibility and Participation* section for guidelines on adding new Dependents.) The Plan Sponsor will forward copies of all Enrollment Applications to EMI Health.

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## COVERED MEDICAL BENEFITS

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**ALL OF THE FOLLOWING OUTLINED BENEFITS ARE FOR THE PARTICIPATING PROVIDER OPTION. IF NON-PARTICIPATING PROVIDERS ARE USED, BENEFITS WILL BE REDUCED TO THE AMOUNT SHOWN UNDER THE NON-PARTICIPATING PROVIDER OPTION COLUMN OF THE SUMMARY OF BENEFITS.**

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### **Hospital/Facility Benefits**

This section provides a general summary of Hospital and Facility Benefits available under the Participating Provider Option. For details as to specific coverages, see the “Summary of Benefits” chart. This section does not apply to Physician and Professional Services, which are addressed separately in this Plan and in the “Summary of Benefits” chart.

Hospitalizations and Inpatient surgeries require Preauthorization. **The Covered Person is advised to verify with the physician that Preauthorization procedures have been followed.** The Plan provides benefits for the following:

- Semi-private room and Intensive care charges.
- Hospital ancillary charges, including operating room, dressings and supplies, and Hospital Outpatient Services rendered in connection with surgery for which the operating room and other Hospital facilities are needed. Hospital ancillary charges include, but are not limited to, the following:
  - Drugs
  - Operating room
  - Medical Supplies
  - X-ray and laboratory expenses
  - Electrocardiograms
  - Chemotherapy or radiation therapy
  - Inhalation therapy
  - Intravenous therapy
- Skilled nursing facility services, up to a maximum of 60 days per year. Admission to a skilled nursing facility must occur within five (5) days of a discharge from a Hospital Confinement.
- Outpatient surgery facility expenses. Some procedures require Preauthorization. Please refer to the list of procedures under the *Preauthorization Requirement* section of this contract.
- Major Diagnostic Testing.

### **Emergency Room (ER) Service Benefit**

The Plan provides benefits for the following:

- Medically Necessary and appropriate ER services are covered according to the “Summary of Benefits” chart.

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- Although payment of the ER Copayment/Coinsurance amount is not required before service may be provided in the ER, it is the Covered Person's responsibility to pay the ER Copayment/Coinsurance listed on the "Summary of Benefits" chart directly to the providing facility.
  - The ER Copayment/Coinsurance covers the facility charges only. The Covered Person may have additional physician and professional charges according to the "Summary of Benefits" chart.

If the Covered Person is admitted directly to the Hospital as an Inpatient because of the condition for which ER services were sought, then the ER Copayment/Coinsurance will be waived. The usual Copayment/Coinsurance amounts normally applied to such a hospitalization will be required.

### **Inpatient Rehabilitation Therapy Benefit**

The Plan provides benefits for all services and treatments in connection with Inpatient rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary). Inpatient benefits are limited to a combined maximum of 30 days per person per year.

### **Accident and Life-threatening Condition Benefits**

The Plan provides benefits for the following:

- Expenses for Accidental Injuries. Accidental benefits apply when treatment commences within 48 hours of the Accidental Injury and is completed within 12 months, unless a delay in treatment is Medically Necessary, or it was not reasonably possible to obtain the necessary medical treatment within 48 hours or complete it within 12 months. If a delay in treatment is necessary, the Covered Person must receive prior approval from the Plan.
- Expenses for Life-threatening Conditions.
- Services provided by a licensed ambulance service for necessary transportation to and from a Hospital, doctor's office, clinic, or other medical institution when the Covered Person's condition is deemed to be a Life-threatening Condition.
- Orthodontic treatment necessary due to an Accident. Accidental Injury benefits apply when treatment commences within 48 hours of the Accidental Injury and is completed within 12 months. If a delay in treatment is necessary, the Covered Person must receive prior approval from the Plan.

### **Physician and Professional Services**

The Plan provides benefits for the following:

- Physician office visits and after-hours physician office visits.
- Inpatient Hospital physician visits.
- Routine prenatal physician visits and delivery expenses. This includes Dependent maternity. A Covered Person may choose to deliver on an outpatient basis. The length of a Hospital stay after a delivery is based on Medical Necessity, except that EMI Health and/or the Plan

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Sponsor may not restrict benefits for any Hospital stay in connection with childbirth for a mother or newborn child for less than 48 hours following a normal vaginal delivery, or for less than 96 hours following a cesarean section, and may not require that a Provider obtain authorization from EMI Health for prescribing a length of stay not in excess of the above periods. The mother or the newborn child's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours or 96 hours, as applicable.

- Surgical and anesthetic procedures including the following:
  - Multiple or bilateral surgical procedures.
  - Surgical procedures rendered during Inpatient hospitalization, as an outpatient, or in a physician's office.
  - Treatment of fractures or dislocations and orthopedic casting.
  - Operative and major diagnostic endoscopic procedures.
  - Therapeutic surgical injections and aspirations, biopsies, and destruction of lesions by chemical, mechanical, or electrical means.
  - Operative and curative procedures rendered by a podiatrist for the treatment of diseases of the feet.
  - Surgical and anesthetic benefits cover expenses incurred for medical treatment rendered on the date of any surgical procedure or during a reasonable convalescent period following any surgery.
  - Physiological conditions resulting from corrective procedures that are not directly related to a previous Reconstructive, Cosmetic, or Plastic Surgery; for example, anesthetic complications, myocardial infarction, venous thrombosis, or anaphylactic reaction.
  - Pump implantation, medication, and related services for Baclofen for the following diagnoses, when criteria are met:
    - Cerebral palsy
    - Brain and spinal cord injuries
    - Multiple sclerosis
    - Post stroke hypertonia
    - Post traumatic brain injury
    - Dystonia in children and generalized secondary dystonia

**Incidental surgical procedures or incidental scar excisions are excluded from coverage.**

- Benefits for the primary surgeon performing a surgical procedure. Pre-operative and post-operative services within the global period of the surgical procedure are included in the allowable surgeon's fee.
- Benefits for an assistant surgeon, only when Medically Necessary and appropriate.
- Benefits for a co-surgeon in the absence of an assistant surgeon, in cases where two surgeons are involved in the same procedure, and if both sets of operative notes indicate the use of co-surgeons.
- Expenses for an anesthesiologist.



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- Preadmission testing.
  - Laboratory and X-ray charges.
  - Home Health/Skilled Nursing Care, including charges of a qualified licensed practitioner for approved private duty nursing.
  - Rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary) must be given to improve the physical capabilities of a Covered Person in an attempt to restore the individual to a previous level of good health. (Outpatient benefits limited to a maximum of 30 visits per person per year.)
  - Chiropractic adjustments of the vertebral column and its immediate articulations, up to a maximum of 10 visits per person per year, subject to EMI Health's criteria.
  - Allergy testing.
  - Allergy serum.
  - Chemotherapeutic medications.

### **Preventive Care Services**

The Plan provides benefits for evidence based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. These include but are not limited to, the following:

- One Routine Physical Examination per person per year.
- One Routine Gynecological Examination per person per year.
- One family history examination per person per year.
- One routine Pap smear per person per year.
- One routine mammogram per person per year.
- One Routine Hearing Exam per person per year.
- One Routine Vision Exam per person per year.
- Routine well-baby care.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC. For current recommendations, refer to <http://www.cdc.gov/vaccines/schedules/index.html>

Immunizations, other than those referenced above, are not covered even if deemed Medically Necessary or administered at the advice of a PCP or any other Provider.

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## Transplant Benefits

The Plan will provide benefits for expenses incurred in connection with liver, bone marrow, heart, pancreas, cornea, lung, and kidney Transplants, including presurgery testing, medical expenses incurred by the donor and/or recipient directly as a result of the Transplant process, the cost of transporting the donated organ, and prescribed medications to inhibit rejection of the Transplant (“Transplant Benefits”). Transplants must be preauthorized and meet specific medical criteria in order for Transplant Benefits to apply. Covered services shall include only those services or supplies provided in connection with a heart, pancreas, cornea, lung, liver, kidney, or bone marrow Transplant that are within the scope of the Transplant Benefits, and shall expressly exclude all other services or supplies provided in connection with an organ Transplant. Non-covered Transplant services or supplies include, but are not limited to, the following:

- Any intestine Transplant.
- Any Transplant of a non-human organ or non-human bone marrow.
- Any services or supplies in connection with the implantation of any artificial organ or device, regardless of whether implantation is a temporary measure while awaiting an available human organ.

## Medical Supplies and Equipment

The Plan provides benefits for the following:

- Medical supplies including, but not limited to, ileostomy supplies, I.V. therapy, oxygen, and surgical dressings.
- Diabetes test strips, insulin syringes, and lancets.
- Durable Medical Equipment. Rental of Durable Medical Equipment (not to exceed purchase price) when Medically Necessary and appropriate for therapeutic use, unless the purchase of an item of Durable Medical Equipment will be less expensive than rental or if such equipment is not available for rental. In most cases, the Plan will make payment on the standard model of Durable Medical Equipment. If additional items of comfort or convenience are desired, it will be the Covered Person’s responsibility to pay for them. **For maximum benefits to be paid, Durable Medical Equipment costing more than \$750 must be preauthorized by submitting a written request, accompanied by a letter of medical necessity, to EMI Health, including a description of the Medical Necessity and the expected length of time that the equipment will be required.**
- Prostheses. Expenses in connection with a Prosthesis will be covered no more than once every five years, except replacement will be covered if the replacement is Medically Necessary due to normal physical growth of the Covered Person.
- Orthotic devices of the feet.
- Growth hormones.
- Pacemakers. Expenses in connection with a pacemaker will be covered no more than once every five years.

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- Deep brain stimulation for treatment of Parkinson’s disease when the patient meets EMI Health’s criteria, a copy of which will be provided upon request.

### **Clinical Trials**

The Plan covers routine costs related to a Qualified Individual’s participation in an Approved Clinical Trial. Routine costs of a clinical trial include all items and services that are otherwise generally available to Covered Persons (i.e. there exists a benefit category; it is not statutorily excluded; and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial. Requires Preauthorization.

Qualified Individual is someone who is eligible to participate in an “Approved Clinical Trial” and either the Insured’s doctor has concluded that participation is appropriate or the Insured provides medical and scientific information establishing that their participation is appropriate.

Approved Clinical Trial is defined as a Phase I, II, III, or IV clinical trial for the prevention, detection, or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federal funded trials, conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

A Participating Provider must be used if there is a Participating Provider that is participating in an Approved Clinical Trial.

Non-covered services or supplies include, but are not limited to, the following:

- The investigational item or service, itself, unless otherwise covered outside of the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g. monthly CT scans for a condition usually requiring only a single scan);
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

### **Employee Assistance Program (EAP)**

An Employee Assistance Program (EAP) is offered. Coverage provided through the EAP is not subject to, or part of, the Mental Health benefits otherwise available under the Plan.

An EAP is designed to offer counseling to address such typical problem areas as abuse, aging, alcohol/drugs, depression, family, grief, managing stress, marriage, parenting, relationships, workplace, and financial and legal services. The EAP program provides a limited number of counseling sessions available at no cost to Employees and their families in a safe and private atmosphere. EAP contact information is included on the EMI Health Care Plus medical identification card.

The decision to use the EAP benefit is voluntary and confidential. Many problems can be addressed directly with the EAP professional, but some may require additional visits to mental health providers. The Covered Person should verify the Provider’s panel status by calling EMI Health’s customer service department at 801-262-7475 or on the Internet at [www.emihealth.com](http://www.emihealth.com).

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## **Mental Health and Drug/Alcohol Treatment**

Mental Health and Drug/Alcohol Treatment will be considered for payment only when provided by a person licensed to provide individual psychotherapy, including a psychiatrist, licensed clinical psychologist, licensed social worker, and/or advanced practice registered nurse. The Plan provides benefits for the following:

- Inpatient Mental Health and Drug/Alcohol Treatment. Requires Preauthorization.
- Outpatient Mental Health and Drug/Alcohol Treatment visits.

Some eligible Mental Health and Drug/Alcohol Treatment services may be provided by a Dayspring/day treatment facility. Pre-notification of these services is recommended since some services provided by Dayspring/day treatment facilities are not covered including but not limited to, convenience items, biofeedback, education, and family therapy. All limits and exclusions of the Plan apply.

## **Additional Benefits**

The following benefits are available only if specific medical criteria are met. The portion a Covered Person pays for these benefits may not apply toward the Coinsurance Maximum. Check the Summary of Benefits chart for details. The Plan provides benefits for the following:

- The following orthognathic procedures, including surgery, Hospital, and anesthesia:
  - Sagittal split osteotomies to advance the mandible
  - Maxillary Lefor I osteotomies
  - Intraoral subcondylar osteotomies to set the mandible back
  - Segmental osteotomies
  - All other orthognathic surgery
- Diagnosis and non-surgical treatment of temporomandibular joint dysfunction (TMJ).
- Total parenteral nutrition (TPN) for both Inpatient and outpatient treatment.
- Treatment of Primary Infertility.
- Reduction mammoplasty, when criteria are met.
- An Indemnity Benefit for Adoption in the amount of \$4,000 shall be available to the Covered Person when all of the following conditions are met:
  - The Covered Person's Plan provides maternity benefits for the Covered Person or the Covered Person's Spouse and coverage is in effect on the date a newborn child is placed for the purpose of adoption.
  - A newborn child is placed for the purpose of adoption with the Covered Person within 90 days after the child's birth and the date of placement is on or after the Covered Person's effective date.
  - The Covered Person submits a written request for the Indemnity Benefit for Adoption along with proof of placement of adoption. Proof of placement shall be a copy of the court order (or its equivalent) showing the date of placement for adoption. The written

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request must contain the child's name, date of birth, and a statement regarding any other health coverage of the adoptive parent(s). The written request shall be addressed to the following address:

EMI Health  
852 East Arrowhead Lane  
Murray, UT 84107-5298

- In the event of adoption of more than one newborn child (for example, twins), the Indemnity Benefit for Adoption applies for each child adopted.
- In the event the Covered Person and/or the Covered Person's Spouse is covered by more than one health benefit plan, the Indemnity Benefit for Adoption shall be prorated between or among the plans so that the full amount provided by both or all of the plans does not exceed \$4,000.
- In the event the Plan excludes care and treatment of pregnancy, the Indemnity Benefit for Adoption is not available to that Covered Person or that Covered Person's Spouse.
- In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety, the Covered Person shall be liable for repayment of the Indemnity Benefit for Adoption. The full amount of such benefit shall be refunded by the Covered Person to EMI Health within 30 days after that date the child is removed from placement.

### **Women's Cancer Rights**

The Plan provides medical and surgical benefits for mastectomies for the diagnosis of breast cancer and other Medically Necessary diagnoses required by the Women's Health and Cancer Rights Act of 1998, and will comply with all the requirements of the Act, including coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and Reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and coverage for complications, including lymphedemas.

### **Cost Reform Information**

Medical cost reform is a high priority for the Plan Sponsor who is eager to help Covered Persons become better-informed health care consumers which, in turn, will provide for more efficient use of the medical benefits under this Plan. The following information is presented in an effort to assist Covered Persons in making better-informed decisions.

- **Admission the Day of Surgery (Same-day Surgery)**  
Many surgeries can be performed on the same day of admission to the Hospital. This means the necessary testing and preliminary operative workup should take place before admission on either an outpatient basis or on the day of surgery.
- **Home Health/Skilled Nursing Care and I.V. Therapy**  
As part of the Plan Sponsor's commitment to medical cost reform, they will arrange for Home Health/Skilled Nursing Care and I.V. therapy if a Covered Person chooses to leave the Hospital earlier than the days allowed for his particular illness. Please contact EMI Health

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for more information on this program or to make arrangements for Home Health Care. Any reduction in the length of stay must have the full knowledge and consent of the physician.

- **Office Surgery**

Many procedures may be performed in a physician's office rather than a Hospital. The Covered Person should ask his physician if the proposed surgery is suitable to be performed as an office surgery.

- **Outpatient Procedures**

Due to advances in medical technology and patient care, it is now possible to have surgery and return home the same day. This type of surgery, known by various terms such as "one-day surgery," "ambulatory surgery," "same-day surgery," and "outpatient surgery," can be performed in a special facility at a Hospital or in a licensed independent Surgical Center.

There are many advantages to outpatient surgery. The first obvious advantage is in the area of cost. There is also the advantage of reduced emotional stress, especially with children. There is also less time spent away from home, thus avoiding needless interruptions in the Covered Person's routine and family activities.

- **Second Opinions**

There are instances when it may be advisable to obtain a second opinion for surgery. If the Covered Person has questions regarding a second opinion, He should contact the EMI Health's Customer Service Department for assistance. If the Plan requests a second opinion, the Maximum Allowable Charge will be paid in full by the Plan, in accordance with this Plan Document.

- **Hospital Bill Audits**

The purpose of the Hospital bill audit is to protect the Covered Person and the Plan from billing errors and unnecessary services. Through these Hospital bill audits, the Plan can help assure that the level of care and the services received are compatible with the amount billed.

Hospital Confinements in which the Hospital charges are over the threshold amount will be evaluated to determine if an audit is necessary. In addition, Hospital bills of less than the threshold amount will be prescreened for billing irregularities and audited when appropriate.

- **Billing Accuracy**

In most cases, the Covered Person knows better than anyone the medical care that He has received. By reviewing Provider billings for accuracy, the Covered Person can make certain that there are no duplicate or incorrect charges. The Covered Person should report any possible discrepancies to EMI Health's Customer Service Department.

- **Claims Edit System**

The American Medical Association publishes standards for the coding of medical procedures. Health care Providers are expected to bill for services based on these guidelines, but errors occasionally occur. EMI Health uses a claims edit system that is programmed to help identify inappropriate billing codes or coding combinations. Any charges that are denied as a result of this claims edit system are identified as such on the Covered Person's Explanation of Benefits. These amounts represent Provider adjustments and are not the

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patient's responsibility. Covered Persons should contact EMI Health if they believe that they are being billed for claims edit system denials.

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## MEDICAL PLAN EXCLUSIONS

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

The Plan does not pay for 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. Services not specified as covered. There is no presumption of coverage.
3. Care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit, or because the billed charges are in excess of the Maximum Allowable Charge, or are for services not deemed to be reasonable or Medically Necessary and appropriate, based upon the Plan's determination as set forth by and within the terms of this document.
4. Any Copayments or Deductibles incurred under this Plan, except as they are applied to the Coinsurance Maximum where applicable.
5. 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 the Plan may advance benefits to or on behalf of the Covered Person in such situations, subject to the Plan's right of Subrogation and reimbursement set forth herein,
6. 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 right to Subrogation and reimbursement set forth herein.
7. 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.
8. Care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any licensed Physician.
9. Care, supplies, treatment, and/or services that are expenses to the extent paid, or which the Member is entitled to have paid or obtain without cost, in accordance with the laws of regulations of any government.
10. Care, supplies, treatment, and/or services of an Injury or Illness not payable by virtue of the Plan's Subrogation, reimbursement, and/or third-party responsibility provisions.



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11. Except as otherwise provided by law, charges for Hospital Confinement, services, supplies, or treatment the Covered Person is not legally required to pay.
  12. Charges for Hospital Confinement, services, supplies, or treatment received while the Covered Person is incarcerated in a correctional facility.
  13. Coverage for Illness or injury as a result of war or any act of war, whether declared or undeclared, or caused while performing service in the armed forces of any country.
  14. Charges for procedures, supplies, equipment, and services, which are not Medically Necessary and appropriate.
  15. Care, supplies, treatment, and/or services that do not restore health unless specifically mentioned otherwise.
  16. Care, treatment, or services provided when there are no symptoms of Illness or injury, or when there is or has been no diagnosis of Illness or injury.
  17. Care, treatment, or surgical procedures incurred primarily for convenience, contentment, or other non-therapeutic purposes.
  18. Expenses in connection with immunizations, unless otherwise listed in this Plan.
  19. Expenses for personal hygiene, convenience, wellness, or preventive care including, but not limited to, buildings, motor vehicles, air conditioners, whirlpool baths, exercise equipment, or other multi-purpose equipment or facilities, related appurtenances, controls, accessories, or modifications thereof.
  20. Convenience items in or out of the Hospital such as guest trays, cots, telephone calls, and other services.
  21. Expenses for preparing medical reports, itemized bills, or claim forms.
  22. Expenses for shipping, handling, postage, sales tax, interest, finance charges, and other administrative charges.
  23. Transportation expenses including, but not limited to, mileage reimbursement, airfare, meals, accommodations, and car rental.
  24. Ancillary charges made by a medical institution, Hospital, clinic, hospice, nursing home, or similar facility to hold or reserve a room during any temporary leave of absence of the Covered Person, or in anticipation of a Hospital stay.
  25. Additional reimbursement based upon the technique, approach, or instruments used in treatment. Payment will be based on the standard base-level method of treatment only.
  26. Any care, treatment, or expenses for Cosmetic procedures or complications thereof, including Reconstructive or corrective procedures done primarily for Cosmetic purposes. A care, treatment, or procedure is considered Cosmetic when it is primarily intended to

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improve appearance or correct a deformity without restoring physical bodily function. Psychological factors such as, but not limited to, poor self-image or difficult peer or social relations are not relevant and do not justify a Cosmetic procedure as being Medically Necessary. The reversal of a non-covered Cosmetic procedure is not covered. This exclusion does not apply to Reconstructive Surgery performed or treatment required under the Women's Health and Cancer Rights Act of 1998.

27. Care, treatment, services, or surgical procedures rendered for abdominoplasties, diastasis recti abdominous, protruding ears, breast enlargement, or gynecomastia, or for complications thereof.
28. Care, treatment, services, or surgical procedures rendered for reduction mammoplasty, unless the patient meets EMI Health's criteria, a copy of which will be provided upon request.
29. Care, treatment, services, or surgical procedures rendered for blepharoplasty, unless the patient meets EMI Health's criteria, a copy of which will be provided upon request.
30. Health services and associated expenses for the surgical treatment and non-surgical medical treatment of obesity (whether morbid obesity or not) including, but not limited to, weight loss programs, except for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. (For guidelines refer to <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>).
31. Expenses in connection with gastric banding, gastric stapling, or digestive bypass, or for complications thereof.
32. Educational or behavioral modification services or counseling including, but not limited to, biofeedback, weight control clinics, stop-smoking clinics, cholesterol counseling, exercise programs, or other types of physical fitness training, except for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. (For guidelines refer to <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>).
33. Confinement, education, or training in a nursing home, rest home, or similar establishment, including an institution that is primarily a school or other institution for training, except an Extended Care Facility as provided in this Plan.
34. Expenses in connection with Custodial Care.
35. Charges in connection with institutional care, including residential treatment or programs, which as determined by the Plan, is for the primary purpose of controlling or changing the environment for the individual.
36. Charges for cognitive therapy.
37. Care or treatment of learning disability, mental retardation, or chronic organic brain syndrome, except services required to diagnose any of the above.

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38. Treatment or services for marriage counseling and any counseling or psychotherapy for relief of family or marital discord, divorce, preparation for marriage, encounter groups, parental counseling, treatment for situational disturbances such as financial or environmental problems, or other types of everyday stresses and strains.
  39. Expenses for treatment of personality disorders, behavior disorders, or chronic situational reactions; occupational, religious, or other social maladjustment; or non-specific conditions such as acts of impulse including, but not limited to, gambling, pyromania, and kleptomania.
  40. Care, treatment, procedures, or services for transsexualism, gender dysphoria, sexual reassignment, psychosexual identity disorder, or psychosexual dysfunction. This exclusion does not apply to the initial assessment and diagnosis of the condition.
  41. Care, supplies, treatment, and/or services for any Injury or Illness which is incurred while voluntarily 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 health conditions).
  42. Care, treatment, or services for any Illness or injury resulting from, or caused by, intoxication or the use of any drug unless such drug is administered or prescribed by a physician and taken in the manner prescribed and unless the patient meets EMI Health's criteria, a copy of which will be provided upon request.
  43. Care, treatment, or services, including Custodial Care, for substance abuse or the aftereffects of substance abuse including, but not limited to, alcoholism, narcotism, or use of hallucinogenic drugs or similar substances, except as specifically provided under Mental Health and Drug/Alcohol treatment.
  44. Infertility services including, but not limited to, the following:
    - Artificial insemination, sperm washing, sperm banking, and/or storage.
    - Donor costs.
    - Experimental or Investigative treatment.
    - Gamete intrafallopian transfer ("GIFT").
    - Hamster egg penetration tests.
    - In-vitro fertilization (IVF).
    - Medications for Infertility and ultrasounds associated with Infertility medications therapy.
    - Non-participating Provider or facility services for Infertility.
    - Zygote intrafallopian transfer ("ZIFT").
    - Surrogate mothers.
    - Secondary Infertility.
    - Expenses in connection with retrieval or collection of semen and/or ovum.

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45. The Adoption Indemnity Benefit (see *Additional Benefit* section) in connection with the adoption of any child over 90 days of age.
  46. The reversal of a surgically performed sterilization, subsequent sterilization, or ovulation-inducing drugs or injections.
  47. Expenses in connection with abortion, except as follows:
    - Where documented by medical evidence that the life of the mother would be endangered if the fetus were carried to term.
    - Where the pregnancy is the result of incest or rape.
  48. Care, treatment, or surgical procedures for erectile dysfunction.
  49. Care, treatment, or devices to aid in female sexual arousal disorder including, but not limited to, Eros Clitoral Therapy Device.
  50. Expenses in connection with a penile prosthesis.
  51. All organ Transplant services when rendered by Non-participating Providers.
  52. Services for cross matching and/or harvesting organs from live or deceased donors for all non-covered Transplant/Implant services and whenever the organ recipient is not a Covered Person.
  53. Repair or replacement of any otherwise covered Implant when rendered by Non-participating Providers.
  54. Expenses for and in connection with artificial hearts, LVAD, LVAS, and ventricular-assist devices.
  55. Duplication, replacement, upgrade, improvement, alteration, or repair of existing Durable Medical Equipment, except this exclusion does not apply to the replacement of Durable Medical Equipment other than Durable Medical Equipment that EMI Health has previously paid for under *Medical Supplies and Equipment*. This includes parts, such as but not limited to, batteries. Replacement of existing Durable Medical Equipment will only be covered if the replacement is Medically Necessary due to normal physical growth of the Covered Person. Expenses related to modifications and/or improvements to home, van, or other vehicle, regardless of medical necessity are excluded. This exclusion does not apply to medical supplies for use with insulin pumps, insulin infusion pumps, or intrathecal pumps.
  56. Care, treatment, or surgical procedures in connection with hearing aids, devices, or implants, including but not limited to cochlear implantation. This exclusion includes the fitting of such devices.
  57. Eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses, with the exception of one lens per operated eye following eye surgery; for example, an external

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- contact lens or surgically implanted intraocular lens. This exclusion does not apply to contact lenses for Keratoconus diagnosis.
58. Radial keratotomy or lamellar keratectomy, or other eye surgery performed primarily to correct refractive errors.
59. Dental, mouth, and jaw services including, but not limited to, all care, treatment, therapy, surgery, or diagnostic procedures for the following, unless otherwise indicated in the “Summary of Benefits” chart:
- Appliances, bite guards, space maintainers, splints
  - Bone resection, bone screws, Implants
  - Crowns or caps, dentures, permanent bridgework
  - Endodontics, nerves within the teeth
  - Full mouth rehabilitation therapy
  - Injection of joints
  - Maxillary and or mandibular osteotomy
  - Orthodontic treatment
  - Orthognathic procedures, upper/lower jaw augmentation or reduction procedures, including problems due to development or altering of vertical dimensions
  - Periodontics, gums alveolar processes
  - Prosthodontic treatment
  - Restorations, including restoration of occlusion
  - Teeth, including nursing bottle syndrome, caries, etc.
  - X-rays
  - Temporomandibular joint disorders (TMJ)
  - Removal of impacted teeth
60. Dental anesthesia. This exclusion does not apply to covered oral surgery, or when treatment is for a Covered Person who is four years old or younger.
61. Services, supplies, or accommodations provided in connection with the following:
- Routine cutting, removal, or other treatment of corns, calluses, or toenails unless deemed Medically Necessary and appropriate due to infection or a metabolic disease such as diabetes mellitus or a peripheral vascular disease such as arteriosclerosis.
  - Orthopedic shoes that are not attached to a brace.
62. Expenses in connection with speech therapy, unless required as a result of speech defects as a result of Illness or Accident.
63. Expenses for whole blood, or blood derivatives.
64. Care, treatment, or services involving acupuncture, acupressure, or hypnosis.

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65. Care, treatment, surgical procedures or supplies, or any appliances, aids, devices, or drugs that are illegal, Experimental, or Investigative as defined in the Plan, or for complications thereof.
  66. Care, treatment, supplies, appliances, aids, devices, or drugs that are 1) not approved by the FDA for the particular medical indication, or 2) are still under investigation, and current peer-reviewed studies or national professional guidelines do not indicate superiority or significant improvement over current, accepted standards of care.
  67. Care, treatment, or services including, but not limited to, testing associated with autogenous urine immunization, sublingual provocation, leukocytotoxicity, and subcutaneous provocation and neutralizing.
  68. Expenses in connection with herbal, holistic, or homeopathic treatment, or for complications thereof.
  69. Genetic counseling and testing except prenatal amniocentesis, chorionic villi sampling for high risk pregnancy, and BRCA counseling regarding genetic testing for women at higher risk.
  70. Expenses related to a sleep laboratory or facility, except services related to sleep apnea, unless otherwise indicated. This includes, but is not limited to, insomnia.
  71. Expenses for any of the following:
    - Ambulance services when the individual could be safely transported by means other than ambulance.
    - Air ambulance services when the Covered Person could be safely transported by ground ambulance or by means other than ambulance.
    - Ambulance services beyond transportation to the nearest facility expected to have appropriate services for the treatment of the injury or Illness involved.
    - Ambulance services for conditions, other than injuries received in an Accident, not deemed Life-threatening.
  72. Special duty nursing services, including the following:
    - That ordinarily would be provided by the Hospital staff or its Intensive Care unit. (The Hospital benefit pays for general nursing service by Hospital staff.)
    - Requested by, or for the convenience of, the Covered Person or the Covered Person's family or consisting primarily of bathing, feeding, exercising, housekeeping, moving the Covered Person, giving medication, or acting as a companion or sitter, or when otherwise deemed not to be Medically Necessary and appropriate.
    - Rendered by a private duty nurse, who is an immediate family member (e.g. Spouse, parent).
    - Home Health aides or services.

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73. Charges for physician calls in excess of one per physician per day, or for a mid-level provider and the supervising Physician in the same day.
74. Expenses for appointments scheduled but not kept.
75. Expenses for telephone consultations or services delivered remotely via email or other telecommunication technologies, except as specifically provided under a telemedicine benefit.
76. Care, treatment, or services rendered by any Provider who ordinarily resides in the same household (e.g. Spouse, parent).
77. Services performed by a Provider that is not covered by the Plan including, but not limited to, the following:
- Acupuncturist
  - Registered dietician
  - Doctor of education
  - Clergy
  - Home Health/nurse aid
  - Hygienist
  - Hypnotist
  - Medical assistant
  - Massage therapist
  - Naturopath
  - Vocational nurse
  - Personal fitness trainer/coach
78. All self-administered Injectables. This exclusion does not apply to the following:
- Neupogen (Filgrastim)
  - Epogen, Procrit (Epoetin Alfa)
  - Lupron, Lupron Depot, Lupron Depot-3 month, Lupron Depot-4 month, Lupron Depot-Ped, Lupron Depot-Gyn, Oaklide (Leuprolide Acetate)
  - Neulasta (Pegfilgrastim)
  - Neumege (Oprelvekin)
  - Leukine, Prokine (Saragramostim)
79. All medications that are excluded under the “Drug Program” are also excluded under Medical. This exclusion does not apply to the following (under Medical plan):
- Chemotherapeutic medications.
  - Otherwise covered medication which is to be taken by, or administered to, an individual, in whole or in part, while He is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

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- Any otherwise covered drug provided under another provision of the Plan; e.g. Inpatient Hospital use.
  - Unit dose packaging of prescription drug products, including but not limited to, Factor VIII.
  - Medically Necessary enteral feeding when administered via nasogastric, gastrostomy, or jejunostomy tube.

80. All services, equipment, and supplies provided or ordered to treat complications of a non-covered illness, injury, condition, situation, procedure, or treatment.

***With respect to any Injury which is otherwise covered by the Plan, the plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a medical condition.***





Southern Utah University  
351 W. University Blvd.  
Cedar City, UT 84720

852 East Arrowhead Lane  
Murray, Utah 84107-5298  
(801)270-2880 / (800)662-5852  
Fax (801)269-9734

**Group:**

**Southern Utah University – (Plan #144)**

Plan:

Premier PPO

Administered By:

Educators Mutual Insurance Association of Utah

Summary of Benefits	EMI Health Dental Plan	
	In-Network	Out-of-Network
<b>Type 1 – Preventive</b> Oral Exams, Cleanings, X-rays, Fluoride	80%	80%
<b>Type 2 – Basic</b> Fillings, Oral Surgery	80%	80%
<b>Type 3 – Major</b> Crowns, Bridges, Prosthodontics	50%	50%
<b>Type 4 – Orthodontics</b> Dependent children	50%	50%
Adults	50%	50%
Orthodontic Discount (All Members)	25% Discount	No Discount
<b>Endodontics</b>	Type 2 – Basic	Type 2 – Basic
<b>Periodontics</b>	Type 2 – Basic	Type 2 – Basic
<b>Sealants</b>	Type 3 – Major	Type 3 – Major
<b>Space Maintainers</b>	Type 1 – Preventive	Type 1 – Preventive
<b>Specialists</b>	Paid same as General Dentists	Paid same as General Dentists
<b>Waiting periods</b>		
Type 2 – Basic		None
Type 3 – Major		None
Type 4 – Orthodontics		None
<b>Deductible</b>		
Per Person	\$0.00	\$0.00
Family Max	\$0.00	\$0.00
<b>Deductible Applies To</b>	N / A	N / A
<b>Annual Maximum Per Person</b>		\$1,500.00
<b>Orthodontic Lifetime Maximum</b>		\$1,000.00
<b>Reimbursement Schedule</b>	Premier Fee Schedule	Premier Fee Schedule
<b>Provisions / Limitations / Exclusions</b>		
Exams (including Periodontal), Cleanings and Fluoride		2 per Contract Year
Fluoride		Any Age
Sealants		Up to age 26
Space Maintainers		Up to age 16
Bitewing X-Rays		Up to 4, twice per Contract Year
Periapical X-Rays		6 per Contract Year
Panoramic X-Ray		1 every 3 years
Impacted Teeth		Covered in Type 2 – Basic
Anesthesia (Age 8 and over for the extraction of impacted teeth only)		Covered in Type 3 – Major
Anesthesia (For children age 7 and under once per Contract year)		Covered in Type 3 – Major
Implants		Covered in Type 3 – Major
Crowns, Pontics, Abutments, Onlays and Dentures		1 every 5 years per tooth
Filings on the same surface		1 every 18 months

Benefits illustrated are in summary only. Refer to your dental booklet for a complete description of benefits, limitations and exclusions. All services are subject to EMI Health Table of Allowances. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Table of Allowances.

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## EMI HEALTH PREMIER DENTAL PLAN

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### 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.

### Space Maintainers

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

### Sealants

- Sealants for Dependent children up to the 26<sup>th</sup> 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 Contract 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. Crowns associated with implants fall under the benefit for crowns and are subject to any limits applicable to that benefit.

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- 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, the eligible Employee, and Spouse.

- 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.

### **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. EMI Health has an alternate treatment clause which governs the amount of benefits EMI Health will pay for treatments covered under the policy. 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.

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## PREMIER DENTAL PLAN EXCLUSIONS

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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 EMI Health may elect to advance benefits to or on behalf of the Covered Person in either situation, subject to EMI Health'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. 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.
8. Plaque control programs, oral hygiene instruction, and dietary instruction.
9. Myofunctional therapy.
10. Lab costs for an oral tissue biopsy.
11. 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.
12. Care, treatment, operations, supplies, appliances, aids, devices, or drugs that are not FDA approved.

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13. Care, supplies, treatment, and/or services for any injury or illness which is incurred while voluntarily 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 health conditions).
  14. 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.
  15. Expenses in connection with transportation or mileage reimbursement.
  16. Expenses including, but not limited to, air fare, meals, accommodations, and car rental.
  17. Medications labeled “Caution, Limited by Federal Law to Investigational Use” or experimental drugs.
  18. 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.
  19. Any procedure or appliance to correct or treat temporomandibular joint dysfunction (TMJ).
  20. Transplants, reimplantations, and associated appliances or services rendered in conjunction with Cosmetic implants.
  21. Hospital services.
  22. Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.
  23. Temporary restorations, appliances, or procedures of any nature, except that temporary restorations are covered when included in the charge for the restoration process.
  24. Replacement of lost, stolen, or damaged dentures, except once every five years.
  25. 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, equilibration, treatment of disturbances of the temporomandibular joint (TMJ), orthognathic procedures.
  26. Hypnosis and related analgesia.
  27. Restorative dental services in connection with an overdenture.

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

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## CONTINUATION OF COVERAGE

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### 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 the Plan Administrator 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*

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**notice.** If the 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.

- **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 the Plan Sponsor ceases to provide any group health plan to any Employee;
  - The date the Covered Person fails to make any required premium payment; or
  - The date the Covered Person becomes either of the following:
    - A covered Employee under any other group health plan, or
    - Entitled to 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 months 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, the Plan Sponsor 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 the Plan Sponsor within 60 days of the date the Employee’s employment ends. The Plan Sponsor 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 19<sup>th</sup> through 29<sup>th</sup> 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.

### **Waiver of Premium**

If a Participant becomes disabled while covered under this Plan, and would otherwise lose coverage, He may apply for either COBRA continuation coverage or for continuation of medical coverage for the Participant and eligible Dependents under the Plan Sponsor’s base plan without payment of the Employee portion of the cost of coverage (Waiver of Premium). The waiver of premium benefit will begin after a continuous six-month waiting period has elapsed.

Election of waiver of premium benefits will be considered a waiver of COBRA rights.



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In order to establish eligibility for the waiver of premium, the Participant is encouraged to supply, within 90 days of the onset of disability or his last Active Work day, evidence that the disability began while He was covered under this Plan. Evidence of disability must be submitted within 12 months of the onset of disability. However, failure to provide evidence of disability within this time period does not invalidate the claim if the Participant shows that it was not reasonably possible to provide evidence of disability within the prescribed time and that notice was given as soon as reasonably possible. The Participant must also pay the required Employee portion of the cost of coverage during the waiting period unless other arrangements have been made by the Plan Sponsor.

During the continuance of coverage under the provisions of this Plan, the Plan Sponsor and EMI Health will require, at least annually, evidence of the existence and continuation of Total Disability and may require an examination of the disabled Participant. If an exam is required by the Plan Sponsor or EMI Health, the Plan Sponsor will be responsible for charges incurred to establish eligibility for continuation of waiver of premium.

If the Participant ceases to be Totally Disabled and is then eligible for coverage under the provisions of this Plan, the coverage will be continued only if the Employee's portion of the cost of coverage payments are resumed.

If the Participant ceases to be Totally Disabled but is not then eligible for coverage under this Plan, the coverage will automatically cease the last day of the month in which eligibility ended. Regardless of disability, the coverage will automatically cease if the Participant fails to furnish evidence of the continuance of disability within 31 days of EMI Health's request for such evidence.

Waiver of premium benefits may continue for a maximum of 24 months, or until age 65, whichever comes first. No additional dependents may be added under the coverage once the premium waiver period starts.

A Covered Person's participation under the Plan ceases on the earliest of the following:

- 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 26<sup>th</sup> 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 provision or amendment resulting in loss of eligibility;
- For the Participant and covered Dependents, the date this Plan is terminated; or
- For any Covered Person, the discovery of fraud or misrepresentation 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 for cause, the termination of coverage will relate back to the effective date of coverage and the Plan Sponsor may recover any overpayments from the Covered Person such that the Plan Sponsor and the Covered Person are returned to the same financial

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position as if no coverage had ever been in force. Termination of a Participant's coverage for cause will also result in the termination of coverage of the Participant's covered Dependents. Employment may be terminated for health care fraud. The termination will be considered for "gross misconduct," and COBRA will not be offered to the Employee, former Employee, or any other qualified beneficiaries.

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## COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

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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 Rule 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 Utah 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 credit 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, EMI Health 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 EMI Health 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 EMI Health 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, EMI Health 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.

If any payment under this Plan exceeds the maximum amount necessary to satisfy this provision, the Plan Sponsor and EMI Health may recover the excess amount from one or more of the following:

- Any person to, or for whom, such payments were made:
  - The Covered Person, limited to a time period of 18 months from the date a payment is made, unless the reversal is due to fraudulent acts or statements or intentional misrepresentation of a material fact by the Covered Person;
  - The Provider, whether Participating or Non-participating, limited to a time period of 36 months from the date a payment is made unless the reversal is due to fraudulent acts or statements or intentional misrepresentation of a material fact by the Covered Person.
- Any other insurance companies.
- Any other organization.

If attempts to recover such overpayments are exhausted, the Covered Person may be responsible for reimbursement to EMI Health. In order to avoid overpayments, it is important for the Covered Person to take responsibility in reporting to EMI Health any changes in the status of other insurance coverage.

Failure to report additional insurance coverage may result in a delay of claims payment.

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.

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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.

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## CLAIMS PROCEDURE

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Except as otherwise provided in this Plan or by Utah law, no benefits provided under this Plan shall be paid to, or on behalf of, a Covered Person unless the Covered Person, or his authorized representative, has first submitted a written claim for benefits to EMI Health, on behalf of Plan Sponsor. 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. The Plan may deny an untimely claim.

### How to File a Claim

Submit properly completed and coded Provider bills (e.g., HCFA 1500) to the following address:

EMI Health  
852 East Arrowhead Lane  
Murray, Utah 84107-5298

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 medical record review process, EMI Health 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 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 EMI Health or its agent to identify the charges deemed in excess of Eligible Expenses or other applicable provisions, as outlined in this Plan Document.

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Despite the existence of any agreement to the contrary, EMI Health has the authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

### **Non U.S. Providers**

Medical 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 the Plan Sponsor, EMI Health, or Plan Administrator and no arbitration request may be made, until the Covered Person has exhausted the Claims Review Process, as provided in this Plan. The Covered Person shall not assign, and has no power to assign, his rights to appeal adverse claims decisions through the Claims Review Process to any agent, assignee, attorney, or authorized representative, except where the Covered Person, by reason of mental, physical, or legal incapacity, is unable to pursue his own appeal. Any attempted assignment inconsistent with the foregoing shall be void.

### **Claims Review Process**

1. The Covered Person may request a review of any claim decision adverse to the Covered Person, in whole or in part, by sending a written request to the **EMI Health Claims Review Committee**. This request must be received within 180 days after the Covered Person receives notice of the adverse decision. As part of this process, the Covered Person should review all pertinent information regarding the claim and explain, in writing, his reasons for believing the claim should have been granted. The Covered Person should also include any additional information that will aid the Claims Review Committee in reviewing the claim. Upon receipt of the request, the Covered Person may be contacted by EMI Health’s member advisor. The Claims Review Committee is composed of at least three employees of EMI Health who did not participate and are not supervised by any person who participated in the initial decision. The Claims Review Committee will inform the Covered Person, in writing, of its decision. If the previous decision on payment of the claim stands, in whole or in part, the Covered Person will be given a specific reason for the decision.
2. If the Covered Person does not agree with the findings of the Claims Review Committee, in whole or in part, the Covered Person may request a review regarding the disputed claim and an in-person hearing by the **EMI Health Board of Directors**. This request must be in writing and must be received by EMI Health, on behalf of the Plan Sponsor, within 180 days after the date of the letter indicating the decision of the Claims Review

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Committee. The EMI Health Board of Directors will inform the Covered Person of its decision and, if adverse to the Covered Person, the basis of its decision.

### **Independent Review**

If after exhaustion of the claims review process provided in this Plan, the Covered Person still disputes a determination of Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness of the healthcare service or treatment, the Covered Person shall have the voluntary option to submit the adverse benefit determination for an independent review.

Requests for review must be submitted to EMI Health within 180 days after the receipt of a notice of an adverse benefit determination. The independent review decision is binding on EMI Health and the Covered Person, except to the extent that other remedies are available under federal or state law.

#### ***Standard Independent Review***

1. Upon receipt of a request for an Independent Review, the Commissioner will send a copy of the request to EMI Health for an eligibility review.
2. Within five business days following receipt of the request, EMI Health will determine eligibility, and within one day of completing the eligibility review will notify the Covered Person in writing whether the request is complete and if it is eligible for independent review.
3. If the request is not complete, EMI Health will inform the Covered Person in writing what information or materials are needed to make the request complete.
4. If the request is not eligible for independent review, EMI Health will inform the Covered Person in writing the reasons for ineligibility.
5. If the request is eligible for independent review, EMI Health shall assign an independent review organization. Within five business days, EMI Health will provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination.
6. The Covered Person may submit additional information to the independent review organization within 10 business days. The independent review organization will forward to EMI Health, within one business day of receipt, any information submitted by the Covered Person.
7. Within 45 calendar days after receipt of the request for an independent review, the independent review organization shall provide written notice of its decision to the Covered Person and EMI Health.
8. Upon receipt of a notice reversing the adverse benefit determination, the Plan shall within one business day approve the coverage that was the subject of the adverse benefit determination.

#### ***Expedited Independent Review***

1. An expedited independent review shall be available if the adverse benefit determination meets any of the following conditions:
  - involves a medical condition which would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function;
  - in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination; or



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- concerns an admission, availability of care, continued stay or healthcare service for which the insured received emergency services, but has not been discharged from a facility.
2. Upon receipt of a request for an Independent Review, the Commissioner will immediately send a copy of the request to EMI Health for an eligibility review.
  3. Upon receipt of the request, EMI Health will immediately determine eligibility and notify the Covered Person in writing whether the request is complete and if it is eligible for independent review.
  4. If the request is not complete, EMI Health will inform the Covered Person in writing what information or materials are needed to make the request complete.
  5. If the request is not eligible for independent review, EMI Health will inform the Covered Person in writing the reasons for ineligibility.
  6. If the request is eligible for independent review, EMI Health will immediately assign an independent review organization. Within one business day, EMI Health will provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination.
  7. The Covered Person may submit additional information to the independent review organization within one business day. The independent review organization will forward to EMI Health, within one business day of receipt, any information submitted by the Covered Person.
  8. The independent review organization shall as soon as possible, but no later than 72 hours after receipt of the request for an expedited independent review, make a decision and notify EMI Health and the Covered Person of that decision. If notice of the decision is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of the notification of the decision.
  9. Upon receipt of a notice reversing the adverse benefit determination, the Plan shall within one business day approve the coverage that was the subject of the adverse benefit determination.

#### ***Independent Review of Experimental or Investigational Service or Treatment***

1. A request for an independent review based on experimental or investigational service or treatment shall be submitted with certification of the following from the physician:
  - Standard healthcare service or treatment has not been effective in improving the Covered Person's condition;
  - Standard healthcare or treatment is not medically appropriate for the Covered Person; or
  - There is no available standard healthcare service or treatment covered by EMI Health that is more beneficial than the recommended or requested healthcare service or treatment.
2. Within five business days (or one business day for an expedited review) following receipt of the request, EMI Health will determine eligibility, and within one day of completing the eligibility review will notify the Covered Person in writing whether the request is complete and if it is eligible for independent review.
3. If the request is not complete, EMI will inform the Covered Person in writing what information or materials are needed to make the request complete.
4. If the request is not eligible for independent review, EMI Health will inform the Covered Person in writing the reasons for ineligibility.
5. If the request is eligible for independent review, EMI Health shall assign an independent review organization. Within five business days (one business day for an

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- expedited review), EMI Health will provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination.
6. The Covered Person may submit additional information to the independent review organization within 10 business days (one business day for an expedited review). The independent review organization will forward to EMI Health, within one business day of receipt, any information submitted by the Covered Person.
  7. Within one business day after receipt of the request, the independent review organization shall select one or more clinical reviewers to conduct the review. The clinical reviewers shall provide to the independent review organization a written opinion within 20 calendar days (five calendar days for an expedited review).
  8. Within 20 calendar days (48 hours for an expedited review) after receipt of the clinical reviewer's opinion, the independent review organization shall provide notice of its decision to the Covered Person and EMI Health.
  9. Upon receipt of a notice reversing the adverse benefit determination, the Plan shall within one business day approve the coverage that was the subject of the adverse benefit determination.

### **Arbitration**

If, after exhaustion of the Claims Review Process provided in this Plan, the Covered Person still disputes the results of the same, the subject claim, controversy, or dispute shall be submitted for resolution through binding arbitration in accordance with the provisions hereof. Controversy over whether or not the subject claim, controversy, or dispute is within the scope of this arbitration clause shall also be subject to such binding arbitration. Such arbitration is mandatory, and by acceptance of this Plan, the Covered Person does knowingly and intentionally agree that binding arbitration is and shall be the exclusive method of resolving any such unresolved claim, controversy, or dispute, unless such claim qualifies for Independent Review.

The Covered Person may initiate arbitration proceedings by giving written notice to EMI Health, on behalf of the Plan Sponsor, of the election to proceed with binding arbitration. A failure to give such notice for more than 180 days after the delivery in writing of the final adjudication from the Claims Review Process shall be deemed to be an acceptance of the said final adjudication as a final and binding adjudication.

The procedures and rules governing the requested arbitration proceeding shall be (1) the terms of this Plan governing arbitration and the procedures for the same and (2) the Utah Arbitration Act (Utah Code Ann. 78B-11-101 et seq). In the event of any inconsistency between the listed procedures and rules, the earlier listed provisions shall govern over the later listed provisions.

The arbitration shall be conducted by a single arbitrator selected by mutual agreement of the Covered Person and EMI Health, on behalf of the Plan Sponsor, from a panel provided by an independent arbitration association. In the absence of an agreement by the parties as to the selection of an arbitrator, the arbitrator named by each of the parties shall, together, select the arbitrator for the proceeding from the said panel.

All costs of the arbitration proceeding shall be borne equally by the Covered Person and EMI Health, on behalf of the Plan Sponsor. Upon request by the selected arbitrator, each party will deposit in advance with the selected arbitrator a sum sufficient to cover the reasonably estimated costs of the arbitration proceeding payable to the arbitrator with respect to the conduct of the

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arbitration proceeding. Any failure to deposit such sums in the time frame required shall entitle the other party to the entry by the arbitrator of a default award in favor of such non-defaulting party in accordance with the relief requested by such non-defaulting party. The parties agree that the award may not include attorneys' fees incurred, regardless of the fact of whether that party prevails in the arbitration proceeding. In other words, the Covered Person and EMI Health, on behalf of the Plan Sponsor, are each responsible for their own attorneys' fees incurred in connection with the claim, controversy, or dispute, whether before, during, or after the arbitration proceeding. The decision and award of the arbitrator shall be final and binding upon the parties. No arbitration request may be made until the Covered Person has exhausted the Preauthorization Review Process, as provided in this Plan.

### **Subrogation and Reimbursement**

When the 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 provide the Covered Person has been made whole.
- 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 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. 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.

In the event the Covered Person fails to reimburse EMI Health for advanced payment of benefits as provided for in this section, then in addition to reimbursement to EMI Health 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

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expenses, and attorney's fees, incurred by EMI Health and/or the Plan Sponsor for collecting the advanced payment(s).

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## DEFINITION OF TERMS

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**Accident** or **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.

**Additional Benefits** means those limited benefits provided by the Plan that are available only if specific medical criteria, established by EMI Health, on behalf of the Plan Sponsor, are met. The portion the Covered Person pays for these benefits does not apply toward the Coinsurance Maximum.

**Adverse Benefit Determination** means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits; or
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.

**Allowable Expenses**, when used in conjunction with Coordination of Benefits, shall have the same meaning as the term "Allowable Expense" in Utah Rule R590-131-3.A.

**Allowable Fee** means the schedule for payment of Eligible Expenses established by EMI Health, on behalf of the Plan Sponsor.

**Ancillary Expenses**, when used in conjunction with Hospital expenses, means services and supplies in excess of daily room and board charges.

**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 is 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:

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- 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.
- Specified disease or specified Accident policies.
- Limited benefit health coverage, as defined in Utah 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 plan, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a plan, 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 of Utah.

**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 “Summary of Benefits” chart.

**Coinsurance Maximum** is designed to insure against financial hardship caused by unexpected expenses from catastrophic illness. The Coinsurance Maximum amount is specified on the “Summary of Benefits” chart. When the Covered Person has satisfied any applicable Deductible and paid Eligible Expenses, including Copayments, up to the Coinsurance Maximum, EMI Health, on behalf of Plan Sponsor, will pay remaining Eligible Expenses at 100 percent of the Maximum Allowable Charge, for the remainder of that Plan Year. The Participating Provider and Non-participating Provider Options each have a separate Coinsurance Maximum.

**Confinement** or **Confine** means an uninterrupted stay following formal admission to a Hospital, skilled nursing facility, or Inpatient rehabilitation facility.

**Conforming Plan** means a COB Plan that is subject to Utah Rule R590-131.

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**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 “Summary of Benefits” chart.

**Contract Year** means the 12-month period beginning each July 1, and ending on the following June 30.

**Covered Person** means an Employee or Dependent who enrolled with the Plan to receive covered services and who is recognized by the Plan as a Covered Person. Employees/retirees of the Plan Sponsor who are eligible to become Covered Persons can choose to enroll Dependents who satisfy the Plan’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.

**Creditable Coverage**, as defined by HIPAA legislation, means coverage under a group health plan, individual insurance, Medicare, Medicaid, S-CHIP, military-service-related coverage (TRICARE), a medical program of the Indian Health Service or of a tribal organization, or a State health benefits risk pool. Creditable Coverage does not include limited-scope dental or vision policies that are issued under a separate policy, or Accident only, disability income, liability, supplement to liability, Workers’ Compensation, automobile medical, or credit-only coverage, or coverage for on-site medical clinics.

**Custodial Care** means maintenance of a Covered Person beyond the acute phase of Illness or injury. Custodial Care may include rooms, meals, bed, or skilled medical care in a Hospital, facility, or at home. Care is considered custodial when its primary purpose is to meet personal needs. Custodial Care may include, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, eating, taking medication, or bowel or bladder care.

**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 Plan.

**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 legally adopted children and children for whom the Participant has legal guardianship) to their 26<sup>th</sup> birthday. A child is considered a Dependent beyond the 26<sup>th</sup> 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 proof of disability and dependency to EMI Health, on behalf of the Plan Sponsor, 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,

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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.

***Durable Medical Equipment*** means a device that meets all of the following conditions:

- Can withstand repeated use.
- Is primarily and customarily used to serve a medical purpose rather than for convenience and/or comfort.
- Generally is not useful to a person in the absence of Illness or injury.
- Is appropriate for use in the home.
- Is Medically Necessary and appropriate.

Durable Medical Equipment includes braces, crutches, and rental of special medical equipment such as a wheelchair, Hospital-type bed, or oxygen equipment. Regardless of Medical Necessity and appropriateness, any home, van, or other vehicle modifications, and/or improvements are not covered benefits.

***Elective Surgery*** means a non-emergency surgery that can be scheduled at least 48 hours after diagnosis.

***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 Expense shall be for the least costly option that is no less effective than any other option.
- Do not exceed the EMI Health Summary of Benefits or 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.

***Emergency Care*** means health care services that are provided for a condition of recent onset and sufficient severity including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in any of the following conditions:

- Placing the patient's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman, or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

***EMI Health*** means Educators Mutual Insurance Association of Utah.



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**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.

**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 any charge that is not eligible for payment under this Plan.

**Experimental or Investigative** means medical treatment, services, devices, medications, or other methods of therapy or medical practices, which are the subject of on-going research. Experimental study, or Investigational arm of an on-going clinical trial, or are otherwise under study to determine maximum tolerated treatment, adverse effects, safety, or efficacy as compared with the standard means of diagnosis or treatment.

- The 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 Surgeon General, or the Utah Medical Association, or by Reliable Evidence.
- Reliable Evidence may include, but is not limited to (a) reports from national, evidence-based, medical-review organizations where the reviews are performed by MD consultants who are Board Certified and have expertise in the particular field; (b) evidence-based guidelines from national, professional specialty societies; and (c) published systematic reviews, meta-analyses, and other evidence-based assessments of recent peer-reviewed publications from authoritative, scientific medical journals performed by experts in the field.

**Extended Care Facility** means an institution, or distinct part thereof, licensed according to state law and operating within the scope of its license.

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**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 employment, as defined by the Plan Sponsor. Employee as used in this Plan means an Employee who is employed 30 hours per week or more unless otherwise provided by the Plan Sponsor.

**Full-time Employee** means an Employee who is employed on a Full-time Basis by the Plan Sponsor. For purposes of this Plan, Full-time Employee shall not include any individual who is classified as a leased employee or independent contractor by the Plan Sponsor, even if such individual is subsequently determined to be, or to have been, a common law Employee of the Plan Sponsor.

**Grace Period** means the period beginning on the payment due date that shall be granted for the payment of any Plan charge, during which time the Plan shall continue in force; however, any claims received for services rendered during the Grace Period will be held for processing until Plan charges are paid in full. In no event shall the Grace Period extend beyond the date the Plan terminates.

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

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**Home Health/Skilled Nursing Care** means medical care and treatment rendered to a sick or injured Covered Person in the Covered Person's home, when the Covered Person is unable to leave his home, is completing treatment that was initiated in the Hospital, and/or care in the final months of life, by a nurse under the written and general supervision of the Covered Person's physician, when such Home Health/Skilled Nursing Care Providers work within an organization or company licensed by the state to provide such medical care and treatment.

**Hospital** means a facility that is so licensed and provides diagnostic, therapeutic, and rehabilitative services to both Inpatients and outpatients by, or under the supervision of, physicians.

**Illness** means a bodily disorder, disease, mental or emotional infirmity, and all Illnesses due to the same or a related cause or causes.

**Implant** means any FDA approved foreign object or device that is surgically inserted.

**Injectable** means any fluid drug or medicine introduced into the body (skin, subcutaneous tissue, muscle, blood vessels, or a body cavity) with a sterile syringe for therapeutic benefit.

**Inpatient** means an individual assigned to a bed in any department of a Hospital, other than an outpatient section, and charged for room and board by the Hospital.

**Intensive Care Room** means a Hospital section, ward, or wing that operates exclusively for critically ill Covered Persons and provides special supplies, equipment, and constant supervision and care by registered nurses or other highly trained Hospital personnel. Any facility maintained for the purpose of providing normal post-operative recovery treatment is not an Intensive Care Room.

**Late Enrollee** means a person who enrolls for coverage at any point after his first 31 days of employment, except in the case of Special Enrollment.

**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.

**Life-threatening Condition** means the sudden and acute onset of an injury or illness where any delay in treatment would jeopardize the Covered Person's life or cause permanent damage to his health. Life-threatening Conditions include, but are not limited to, loss of heartbeat, loss of consciousness, convulsions, stopped or severely obstructed breathing, food poisoning, or massive uncontrolled bleeding.

**Major Diagnostic Testing**, when used in conjunction with a medical procedure or diagnosis, is interpreted according to generally accepted medical practice and definitions. For this Contract Year, a Major Diagnostic Test is defined as a CT Scan, magnetic resonance imaging (MRI), or nuclear medicine (NMR). This distinction is for the benefit or convenience of the Covered Persons and may change without prior notice to Covered Persons.

**Mastectomy** means the surgical removal of all or part of a breast.

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**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 following:

1. The Table of Allowances;
2. The Usual and Customary Charge;
3. The actual billed charges for the covered services.

The Plan has the discretionary authority to decide if a charge is a Usual and Customary Charge and for a Medically Necessary and reasonable service.

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.

**Medical Supplies** include, but are not limited to, items such as oxygen or surgical dressings.

**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.
- 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.

**Medicare** means the Hospital and Supplementary Insurance Plan established by Title XVIII of the Social Security Act of 1965, as amended.

**New Enrollee** means a person who enrolls for coverage during his first 31 days of employment or under Special Enrollment rights.

**Non-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 is not a Participating Provider. First Health providers in Utah are Non-participating Providers.

**Open Enrollment** means the period, as defined by the Plan Sponsor, during which an Employee may apply for insurance coverage for himself or his Dependents.

**Outpatient Services** means services rendered at a Hospital or ambulatory Surgical Center to Covered Persons who are not charged for room and board, but receive treatment and return home the same day.

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**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.

**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. Outside of Utah Participating Providers include First Health providers. First Health providers in Utah are considered Non-participating Providers.

**Period of Confinement** means the time the Covered Person is confined in a medical facility on an Inpatient basis.

**Plan** means the EMI Health Care Plus Plan.

**Plan Sponsor** means Southern Utah University.

**Plan Year** means the 12-month period beginning each July 1 and ending on the following June 30.

**Preauthorization** means the procedure a Provider and/or Covered Person must follow in order to assure the medical necessity and appropriateness of care, as well as benefit eligibility. Preauthorization procedures must be followed in order for a Covered Person to receive the maximum benefits available under this Plan for Inpatient stays and other specified procedures.

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

**Primary Infertility** means a person has never been able to conceive a child.

**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.

**Prosthesis** means an artificial substitute for a missing body part, such as an arm, leg, or eye, used for functional reasons.

**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.

**Reconstructive, Cosmetic, or Plastic Surgery** means any surgery performed primarily to improve physical appearance.

**Routine Exam** means a hearing, vision, gynecological, or physical exam, including well-baby care, when the physician bills using a preventive diagnosis code rather than a medical diagnosis code.

**Secondary Infertility** means a condition where a person has been able to conceive at least once.

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**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.

**Security Standards** means the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

**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 regulations. The Participant must complete a new enrollment form and submit it to the Plan Sponsor within 31 days of any change in coverage or status.

**Spouse** means the legal relationship established between a man and a woman as recognized by the laws of this State.

**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 Plan.

**Surgical Center** means any facility duly licensed and operating within the scope of its licensure.

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

**Total Disability or Totally Disabled** means the inability of a Participant to perform his regular occupation. Participants are not disabled if they are capable of performing similar duties for the same employer.

**Transplant** means an organ or tissue taken from the body for grafting into another area of the same body or into another individual. (Not withstanding this definition, refer to the covered Transplant section in the Plan description.)

**Usual and Customary Charge** means the charge identified by the Plan Administrator, taking into consideration the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be a Usual and Customary Charge, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by

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other medical professionals with similar credentials, or health care Facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred. The Plan Administrator will determine whether the charge for a specific procedure, service, or supply is Usual.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale. The Plan Administrator will determine whether the charge for a specific procedure, service, or supply is Customary.

The term “Usual and Customary Charge” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies.

Usual and Customary Charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer’s retail pricing (MRP) for supplies and devices.

**All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.**

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**SOUTHERN UTAH UNIVERSITY  
SELF-FUNDED EMPLOYEE MEDICAL  
BENEFIT PLAN(S)**

**SOUTHERN UTAH UNIVERSITY**

**NOTICE OF PRIVACY PRACTICES**

**Effective: July 1, 2014**

**If you participate in any of the following benefits:**

- **Medical Benefits**
- **Dental Benefits**
- **Vision Benefits**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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## Section 1. Introduction

Southern Utah University Self-funded Employee Medical Benefit Plan(s) is dedicated to maintaining the privacy of your health information. This Notice governs the self-insured programs provided under the Plans, as well as those benefits that the Health Plan provides to you through the purchase of insurance from Educators Mutual Insurance Association (“Educators”) (e.g. vision benefits). This notice is on behalf of Southern Utah University Self-funded Employee Medical Benefit Plan(s) with regard to medical and dental benefits and on behalf of Educators with regard to vision benefits (collectively “The Health Plan”).

The Health Plan is required by law to maintain the privacy of your personally identifiable health information or “Protected Health Information” (“PHI”) and to inform you about:

- how it uses and discloses your PHI;
- your privacy rights with respect to your PHI;
- the Health Plan’s duties with respect to your PHI;
- your right to file a complaint with the Health Plan or with the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Health Plan’s privacy practices.

The term “Protected Health Information” or “PHI” means all individually identifiable health information transmitted or maintained by the Health Plan, regardless of form (oral, written, electronic).

The Health Plan is required to comply with the terms of this Notice. However, the Health Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Health Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is changed, a revised version of this Notice will be provided to all individuals then covered under the Health Plan for whom the Plan still maintains PHI. The revised notice will be posted on the Health Plan’s website at [www.educatorsmutual.com](http://www.educatorsmutual.com) and will be sent to you via e-mail.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual rights, the duties of the Health Plan or the other privacy practices described in this Notice.

## Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. Please note that Utah Law may impose additional restrictions on how the Health Plan may use and/or disclose specific types of health information (e.g., health information that relates to HIV/AIDS, domestic violence/abuse and substance abuse and chemical dependency) beyond those described below. In other words, we may further restrict the uses and disclosures described herein for the types of information listed above, where required by state law in Utah.

### A. Required PHI Uses and Disclosures

Upon your request, the Health Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Health Plan’s compliance with the privacy regulations.

The Health Plan also may disclose PHI to Southern Utah University Self-funded Employee Medical Benefit Plan(s), Southern Utah University for administrative purposes permitted by law and related to treatment, payment, or health care operations. Southern Utah University has amended its plan documents to protect your PHI as required by federal law.



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The following categories describe the different ways in which the Health Plan (and its business associates, as applicable) may use and disclose your PHI.

*B. Uses and disclosures to carry out treatment, payment and health care operations*

The Health Plan may use and disclose your PHI to carry out treatment, payment and health care operations.

*Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Health Plan may disclose to a treating specialist the name of your physician so that the specialist may ask for your lab results from the primary care physician.

*Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for Medical Necessity and appropriateness of care and utilization review and preauthorizations).

For example, the Health Plan may inform a physician whether you are eligible for coverage or what percentage of the bill will be paid by the Health Plan.

*Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. The Health Plan may not use or disclose PHI that is genetic information for underwriting purposes.

For example, the Health Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Health Plan may also use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

*C. Authorized uses and disclosures*

You must provide the Health Plan with your written authorization for the types of uses and disclosures that are not identified by this Notice or permitted or required by applicable law. In addition, your written authorization generally will be obtained before the Health Plan will use or disclose psychotherapy notes about you from your mental health professional. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Health Plan may use and disclose such notes when needed by the Health Plan to defend against a legal action or other proceeding filed by you, and in other limited instances, without your written authorization.

Any authorization you provide to the Health Plan regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, the Health Plan will no longer use or disclose your PHI for the reasons described in the authorization, except for the two situations noted below:

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- The Health Plan has taken action in reliance on your authorization before it received your written revocation; or
  - You were required to give the Health Plan your authorization as a condition of obtaining coverage.

*D. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release*

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

*E. Uses and disclosures for which consent, authorization or opportunity to object is not required*

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law. PHI may also be disclosed to a public health authority authorized to receive reports of child abuse, under certain circumstances.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Health Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met.
- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person, provided certain requirements are met. The Health Plan may also disclose PHI about an individual who is or is suspected to be a victim of a crime, under certain circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct if the Health Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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### **Section 3. Rights of Individuals**

#### *A. Right to Request Restrictions on PHI Uses and Disclosures*

You may request that the Health Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Health Plan is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

If you wish to make a request to restrict uses and disclosures of your PHI, you should make your request at the address listed at the end of this Notice.

#### *B. Right to Request Communications by Alternative Means/Locations*

The Health Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you state that the disclosure of all or part of your PHI could endanger you.

You or your personal representative will be required to complete a form to request alternative communications.

If you wish to make a request for communications by alternative means, you should make your request to the address listed at the end of this Notice.

#### *C. Right to Inspect and Copy PHI*

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set” for as long as the Health Plan maintains the PHI.

“*Designated Record Set*” includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan, or other information used by the Health Plan to make decisions about individuals.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If you wish to make a request for access, you should make your request to the address listed at the end of this Notice.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. If the Health Plan is unable to meet this timeline, it may exercise a single 30-day extension under certain circumstances.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights, if any, and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

#### *D. Right to Amend PHI*

You have the right to request the Health Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You or your personal

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representative will be required to complete a form to request amendment of the PHI in your designated record set.

If you wish to make a request to amend PHI, you should make your request to the address listed at the end of this Notice.

The Health Plan has 60 days after the request is made to act on the request. A single 30-day extension is permitted if the Health Plan is unable to comply with the deadline. If your request is denied in whole or part, the Health Plan must provide you with a written explanation of the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

*E. Right to Receive an Accounting of PHI Disclosures*

At your request, the Health Plan will also provide you with an accounting of disclosures by the Health Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; or (3) pursuant to your authorization.

If you request more than one accounting within a 12-month period, the Plan may charge a reasonable, cost-based health fee for each subsequent accounting.

You or your personal representative will be required to complete a form to request an accounting.

If you wish to make a request for an accounting, you should make your request to the address listed below at the end of this Notice.

If the Health Plan cannot provide you with an accounting within 60 days, a single 30-day extension is permitted, provided the health plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

*F. The Right to Receive a Paper Copy of This Notice Upon Request*

To obtain a paper copy of this Notice contact:

Privacy Officer  
Educators Mutual Insurance Association of Utah  
852 East Arrowhead Lane  
Murray, Utah 84107-5298  
Telephone: Salt Lake City (801) 262-7476  
Outside Salt Lake City (800) 662-5850  
Outside Utah (800) 548-5264

*G. A Note About Personal Representatives*

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- proof that the individual is the parent of a minor child.

The Health Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under

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these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

**Section 4. Your Right to File a Complaint With the Plans or the HHS Secretary**

If you believe that your privacy rights have been violated, you may complain to the Health Plan in care of:

Southern Utah University  
Director of Human Resources  
351 W. University Blvd.  
Cedar City, Utah 84720  
(435) 586-7754

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

The Health Plan will not retaliate against you for filing a complaint.

**Section 5. Whom to Contact at the Plan for More Information**

If you have any questions regarding this Notice or the subjects addressed in it, or would like to exercise one or more of your individual rights you may contact:

Southern Utah University  
Director of Human Resources  
351 W. University Blvd.  
Cedar City, Utah 84720  
(435) 586-7754

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## NOTICE

Southern Utah University is required by law to provide you with the following NOTICE. This does **not** represent a change in your coverage.

Your plan is already in compliance with this mandate and provides coverage for this benefit.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides important protections for patients who elect breast reconstruction in connection with a mastectomy.

For a Member who receives benefits in connection with a mastectomy and who elects breast reconstruction, covered services will be provided in a manner determined in consultation with the attending physician and the patient for the following:

- (1) All stages of reconstruction of the breast on which the mastectomy was performed;
- (2) All stages of surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (3) Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Benefits for the above services are subject to the same subscriber cost-sharing provisions (i.e., deductible, copayment, and coinsurance) as those established for other covered services.

If you would like more information on WHCRA benefits, call your Plan Administrator:

- In Salt Lake                      801-262-7475
- Out of Salt Lake                800-662-5851
- Out of State                      800-362-0533

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## PRESCRIPTION DRUG PROGRAM

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### Benefit Advocates

VRx's Benefit Advocates team is available to assist you Monday through Friday 7:00 a.m. -7:00 p.m. Mountain Time (MT). To better serve you, the first hours on Wednesday are dedicated to training and the VRx Benefit Advocates are available by 9:00 a.m. MT.

Local	(801) 417-9722
Toll Free	(877) 879-9722

### Summary Plan Description

Throughout this section, you will see references to the Summary Plan Description (SPD). The SPD is a summary of your medical, pharmacy, and other benefits and was provided to you in your Summary Plan Description (SPD) handbook of the Plan. Please contact EMI Health for another copy of your SPD.

### Coverage Tiers

Prescriptions covered by the Plan are categorized in three separate tiers as listed below:

Type of Medication	Tier
Generic	Tier 1
Formulary Brand	Tier 2
Non-Formulary Brand	Tier 3

Your plan has a separate benefit for specialty medications. *Specialty medications* treat chronic complex conditions such as Rheumatoid Arthritis, Cancer, Multiple Sclerosis, Hepatitis C, Crohn's Disease, Bleeding Disorders, Asthma, Psoriasis, and more. Specialty prescriptions covered by the Plan are categorized in four specialty tiers as listed below:

Type of Medication	Tier
Specialty Preferred	Tier 1
Specialty Formulary	Tier 2
Specialty Non-Formulary	Tier 3
Specialty Excluded	Tier 4

Your financial responsibility for each tier is based upon the benefits offered by your plan. Please refer to your SPD for specific details. For more information regarding your coverage and estimated drug costs, visit the Benefit Information section of the VRx website at [www.myvrx.com](http://www.myvrx.com) or call the VRx Benefit Advocates at (801) 417-9722 or (877) 879-9722.

### Generic Medications

Generics have the same active ingredients in the same dose as brand-name drugs and have been approved by the Food and Drug Administration (FDA) to be safe and effective. Generic drugs generally cost less than brand-name drugs. These savings are passed on to you when you receive a generic medication. Talk to your doctor or pharmacist to see if a generic (tier 1) drug is right for you.

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## Covered Formulary Brand Medications

Brand drugs that are covered by your plan.

## Covered Non-Formulary Brand Medications

Non-formulary brand medications are drugs that are covered by your plan, but at more of a cost to you. Non-formulary brand medications may have a generic equivalent available, or there may be another brand medication that is used to treat the same condition that is generally more cost effective without compromising quality.

## Specialty Medications

*Specialty medications* treat chronic complex conditions such as Rheumatoid Arthritis, Cancer, Multiple Sclerosis, Hepatitis C, Crohn's Disease, Bleeding Disorders, Asthma, Psoriasis, and more. These high cost drugs come in many forms and may be taken orally, injected with a syringe and needle, or even inhaled with a nebulizer. These medications require special handling or a higher level of support than traditional medications. Your *specialty medication* can be delivered to your home, your *provider's* office, or any approved location.

## Formulary Drug List Development and Changes

The VRx Pharmacy and Therapeutics Committee may, in its professional judgment, modify Medications and supplies, on the Formulary Products List as follows:

- Place products on the Prescription Drug Formulary and remove products from the Prescription Drug Formulary.
- Place certain products on the Prior Authorization List and remove products from the Prior Authorization List.
- Categorize certain Non-Prescription Products (over-the-counter products) as a Covered Expense, according to Covered Expenses as listed in the Summary Plan Description.
- Place Medications into and remove Medications from the Specialty Pharmacy Program.
- Place and remove limitations or restrictions on products based on clinical best practice as published in peer reviewed literature. This includes quantity limits, age limits, concurrent therapy, and other administration methods to provide clinically appropriate products to Covered Persons.
- Exclude medications from coverage based on factors such as FDA labeled use, other available therapies, safety concerns, or waiting for sufficient broad-population utilization data on new medications.

Actions by the Pharmacy and Therapeutics Committee take place quarterly, as medical technology evolves, as indications change, or as Food and Drug Administration (FDA) guidelines change. The Pharmacy Benefits Administrator, VRx, will inform participants of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when benefits under this Plan are affected.

## Drugs With Special Requirements

Your health, safety, and well-being are important. VRx works closely with your doctor in order to ensure that you are taking the right medication at the right time. Preauthorization, step therapy, and clinical edits are some of the programs the VRx uses. For a list of drugs that have specific requirements visit the Benefit Information section of the VRx website at [www.myvrx.com](http://www.myvrx.com).



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**Preauthorization.** Some medications require preauthorization and are only approved for certain conditions. Your doctor must submit a preauthorization request to VRx to determine coverage. Once VRx has reviewed the request your doctor will be notified of the decision. If the request is approved, VRx will work with the pharmacy to get the prescription ready for you to pick up. If the request is denied, a representative of VRx will contact you to discuss the decision, provide alternative coverage, if available, and provide direction for follow up with your doctor.

**Step Therapy.** Other medications require step therapy, which means that you must have tried and failed other medications that treat the same condition and are generally more cost effective without compromising quality. Step therapy may be waived (with a preauthorization request) if determined to be medically necessary. The use of samples does not waive the step therapy requirement.

**Quantity Limits.** Quantity Limits are placed on certain medications to ensure that the amounts prescribed are within the recommended dosages specified by the Food and Drug Administration (FDA). Quantity Limits are set to ensure appropriate use and safety. Limits can be accumulative which means that the number of pills or units dispensed will be counted over time and across strengths and formulations of the same medication or medications that treat the same condition.

Your physician can request an exception to quantity limits and step therapy through the preauthorization process.

### **Filling a Prescription**

You have multiple options to obtain your prescriptions.

- **Retail.** When your prescription is filled at a retail pharmacy, you may receive up to a 30-day supply per copay. However, you can receive up to a 90-day supply of maintenance drugs at a participating 90-day retail pharmacy. Contact a VRx Benefit Advocate at (801) 417-9722 or (877) 879-9722 to locate a participating 30-day or 90-day retail pharmacy.
- **Mail Order.** By using the mail order benefit, you can receive up to a 90-day supply of your prescription delivered to your home at no additional charge. To learn more about mail order visit the mail service page on the VRx website at [www.myvr.com](http://www.myvr.com) or call VRx at (801) 417-9722 or (877) 879-9722. A copay applies each time a prescription is filled through mail order.
- **Specialty.** VRx has contracted with specialty pharmacies to meet the needs of members using specialty medications. If you are using a Specialty Medication, please contact a Benefit Advocate for additional details. Each fill of a Specialty Medication may be for up to a 30-day supply.

In order to fill a prescription for a 90-day supply (through Retail or Mail Order), your prescriber must write your prescription for a 90-day supply.

### **Generic Dispensing Required**

This plan requires the pharmacy to dispense a generic medication whenever a brand medication has a generic available. Generics have the same active ingredients in the same dose as brand-

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name drugs and have been approved by the Food and Drug Administration (FDA) to be safe and effective. Generic drugs generally cost less than brand-name drugs.

If you, not your physician, request the pharmacy to dispense a brand medication when a generic is available, you are responsible to pay the higher copay in addition to the difference in cost between the brand and generic medication (Brand Penalty). If your physician requires the brand be dispensed over the generic by indicating on the prescription “Dispense as Written,” the brand will be covered at the non-formulary brand coinsurance.

The Brand Penalty does not apply to your annual pharmacy out-of-pocket maximum.

### **VRx Participating Pharmacy Network.**

You can use your VRx pharmacy benefits at more than 63,000 participating pharmacies. The VRx network includes national pharmacy chains, local and regional chains, many independent pharmacies, and specialty pharmacies. To find out if your pharmacy is participating, visit [www.myvrx.com](http://www.myvrx.com) or call VRx at (801) 417-9722 or (877) 879-9722.

Make sure to present your Insurance ID card that includes the VRx logo with your prescription. If you use a pharmacy that is not in the VRx network or do not present your Insurance ID card, you will be required to pay the full cost of the prescription and then submit for reimbursement. If the prescription is covered you will be reimbursed the contracted rate, less any applicable deductible or copay/coinsurance. In most cases, the pharmacy’s cash price is more than VRx’s contracted rate, which will leave you responsible to pay for an additional amount. To avoid paying any unnecessary expenses make sure to use a participating pharmacy.

### **VRx Secure Website**

You can learn more about your prescription benefit online. Visit [www.myvrx.com](http://www.myvrx.com), register your information and log into the secure member portal. You can find the following helpful information and tools on the VRx website:

#### ***Benefit Information***

- Prescription copay information
- Estimated drug costs
- Prescription claim history report
- Find a participating pharmacy
- Find a list of covered drugs as well as those that have special requirements

#### ***Order Mail Order Prescriptions Online***

- Register for home delivery mail order
- View order status
- Request a refill

#### ***Customer Support***

- View or print a copy of the VRx formulary
- Print a member reimbursement form
- Contact VRx

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## Coordination of Benefits

Coordination of Benefits is when you have coverage through more than one insurance company and they work together to pay for a prescription. This plan does allow for coordination of benefits on pharmacy claims.

## Preventive Medications

One element of the Affordable Care Act is the coverage of certain preventive medications at no cost to the member. As required by law, these medications are covered by the Plan at no cost to you when age and gender appropriate, prescribed by a health care professional, and filled at a network pharmacy. Types of preventive medications include:

- Contraceptives, including, oral, vaginal, transdermal, and injectable.
- Emergency contraception
- Fluoride
- Aspirin
- Folic acid
- Certain vitamins
- Smoking cessation medications
- Immunizations

VRx has determined that contraceptives containing the same progestin are equivalent to each other. Each unique progestin contraceptive medication is represented as a Preventive Care Medication to ensure women have access to a broad range of contraceptives at no cost. All other contraceptives may be covered in other tiers at the applicable copay.

Unless specifically stated, medications available without a prescription over-the-counter (OTC) are not covered by the Plan.

For more information about preventive medications, please visit:  
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

## Exclusions

1. **Administration.** Any charge for the administration of a covered or non-covered Prescription Drug. This exclusion does not apply to, vaccines (flu, pneumonia, herpes zoster, etc.) billed to VRx and administered by the pharmacy on the date of service.
2. **Appetite suppressants / Weight-loss medication.** A charge for appetite suppressants, dietary supplements, or anorexiant used for weight loss.
3. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it was dispensed.
4. **Devices.** Devices of any type, even though such devices may require a prescription. These include, but are not limited to therapeutic devices, artificial appliances, braces, support garments, or any similar device.
5. **Chemotherapy.** A charge for chemotherapeutic medications, administered by IV or injection.
6. **Cosmetic Indication/ Purpose.** Charges for drugs used for cosmetic purposes, including but not limited to anabolic steroids, Retin A, or medications for hair growth or removal.
7. **Experimental.** Experimental drugs and medicines, even though a change is made to the covered person.

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8. **FDA.** Any drug not approved by the Food and Drug Administration.
  9. **Impotence.** A charge for any medication used for erectile dysfunction.
  10. **Fertility.** A charge for fertility medication (Primary or Secondary Infertility).
  11. **Injectables.** A charge for any non-self-administered injectable.
  12. **Investigational.** A drug or medicine labeled “Caution – limited by federal law or investigational use.”
  13. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
  14. **No charge.** A charge for Prescription Drugs which may be properly received without charge under workman’s compensation, local, state, or federal programs.
  15. **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
  16. **No prescription necessary.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
  17. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by a physician.
  18. **Unit dose.** Any medication dispensed in unit dose packaging, including but not limited to, Factor VIII.

### **Appeals Procedures**

Requests for coverage determination or appeals relating to the pharmacy benefit should be sent in writing along with any other pertinent information you wish VRx to review in conjunction with your appeal. Send all information to:

VRx  
Attn: Appeals  
P.O. Box 9780  
Salt Lake City, Utah 84109-0780

If your appeal is denied, VRx will provide written notification to you or your authorized representative. Written notification will include the following:

1. The specific reasons(s) for the denial;
2. Reference to the specific Plan provision on which the adverse benefit determination was based.

### **Second Level Appeal**

If your appeal is denied, you or your authorized representative may request further review by VRx. This request for a second-level appeal must be made, in writing, within sixty (60) days of the date you are notified of the original appeal decision.

VRx will promptly conduct a full and fair review of your appeal, independently from the individual(s) who considered your first level appeal or anyone who reports to such individual(s) and without affording deference to the initial denial.

Second-level appeals will be decided by VRx within a reasonable period of time, but not later than thirty (30) days after VRx receives the appeal. VRx’s decision will be provided to you in writing, and if the decision is a second denial, the notification will include all of the information described above.

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### **Voluntary External Appeal – IRO**

A voluntary appeal to an Independent Review Organization (IRO) is available, but only after you have exhausted all of the applicable non-voluntary appeals, or if VRx has failed to adhere to all claims and internal appeal requirements. Voluntary external appeals must be requested within four months of your receipt of the notice of the prior adverse decision. VRx will coordinate voluntary external appeals, and the decision is made by an IRO at no cost to you. VRx will provide the IRO as no cost to you. VRx will provide the IRO with the appeal documentation. The IRO will make its decision and provide you with its written determination. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under federal law.

The voluntary external appeal by an IRO is optional and you should know that other forums may be utilized as the final level of appeal to resolve a dispute you have under the Plan.

Please refer to the Claims Review Process section of this SPD for additional details.

### **Additional Information on Prescription Benefits**

For more information about these Prescription benefits, please call the Pharmacy Benefits Administrator, VRx at 1-877-417-9722, or visit the website at [www.myvrx.com](http://www.myvrx.com).