INTRODUCTION

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

EMI Health's vision benefits and administrative procedures are described in this handbook. You are urged to read it 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.

This handbook is a summary only; it is not a contract. Some of the information contained in this handbook may not pertain to your specific plan. Check the “Summary of Benefits” chart for information regarding your benefits or refer to the Group Policy for a more complete description of your coverage. The policy is available for your review from your employer or from EMI Health during regular business hours.

Not withstanding anything else in the Plan to the contrary, the items listed in the “Vision Plan Exclusions” section are not covered by the Plan.

Regardless of benefits specified, this Plan 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:

- Be sure all charges are for services actually provided.
- Ask about the price; charges should be competitive.

An Insured who is eligible for Medicare has the right to return this policy for any reason within 30 days after its delivery and to have the premium refunded.

If you need more information on any of the EMI Health plans or 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
This EMI Health Vision Plan is administered and underwritten by Educators Mutual Insurance Association of Utah.
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Vision Examination
A vision examination is covered according to the “Summary of Benefits” chart. Vision examinations include these services:
- A case history.
- External examination of the eye and adnexa.
- Ophthalmoscopic examination.
- Determination of refractive status.
- Binocular balance testing.
- Tonometry test for glaucoma, when indicated.
- Gross visual fields testing, when indicated.
- Color vision testing, when indicated.
- Summary finding.
- Recommendations, including prescribing of corrective lenses.

Prescribed Lenses and Frames
Two prescribed lenses are covered according to the “Summary of Benefits” chart. Frames are covered according to the “Summary of Benefits” chart.

Benefits for lenses and frames include the following directly related Provider services:
- Facial measurements and determination of interpupillary distance.
- Assistance in selection of frames.
- Procurement of lenses as prescribed.
- Verification of lenses as prescribed.
- Follow-up care for a reasonable period of time for fitting and adjustment of prescribed eyewear.

Contact Lenses
Permanent contact lenses used to correct vision are covered according to the “Summary of Benefits” chart. Disposable contacts, in lieu of permanent lenses, are also covered according to the “Summary of Benefits” chart.

Benefit Maximums
The benefits provided under this policy are subject to the maximums outlined on the “Summary of Benefits” chart.

Medically Necessary
This policy authorizes payment for Medically Necessary services and treatment subject to the policy provisions. All benefits are limited by what is determined to be Medically Necessary, as defined in this policy.

All benefits will be paid as set forth in the “Summary of Benefits” chart. The Plan, regardless of benefits specified, will reimburse or pay any claim only if the services rendered are determined to be Medically Necessary. Determination of “medical necessity” will be made by EMI Health using its own set of criteria, or by an independent contractor appointed by EMI Health.
**Coinsurance Payments**
EMI Health will pay Eligible Expenses, less any applicable Coinsurance payments or Deductibles, as defined in this policy and shown on the “Summary of Benefits” chart.

Discounts, per diem, global fees, or any other arrangements entered into by EMI Health with Providers of services or products will not affect the Coinsurance payment responsibility of the Member.
Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered in the Plan.

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

1. Expenses for preparing vision reports, itemized bills, or claim forms.

2. Diagnostic services, other than those provided as a component of a vision examination.

3. Drugs or medications not administered for the purpose of a vision examination.

4. Services, procedures, or supplies determined by the policy to be special or unusual including, but not limited to, orthoptics, vision training, and low vision aids.

5. Charges for non-prescription sunglasses or other special purpose non-prescribed vision aids.

6. Charges for duplicate or spare eyeglasses, lenses, frames, or contact lenses, even to replace lost, broken, or stolen lenses, frames, or contact lenses.

7. Eligible Expenses incurred before coverage under this policy begins or that extend after coverage under this policy ends.

8. Charges for vision care, services, or supplies resulting from participation in, or in consequence of having participated in, the commission of an assault or a felony.

9. Medical or surgical treatment, care, services, or procedures.

10. Illness or injury caused by the negligent or wrongful act of another, or for which the Member is covered by any workers’ compensation or similar law; except that EMI Health may advance benefits to or on behalf of the Member in such situations, subject to EMI Health’s right of Subrogation and reimbursement set forth herein.

11. Illness or injury that a Member 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 Member, except that EMI Health may elect to advance benefits to or on behalf of the Member in either situation, subject to EMI Health’s rights of Subrogation and reimbursement set forth herein.

12. Illness or injury for which the Member is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, underinsurance motorist coverage, or uninsured motorist coverage, except as otherwise provided herein, or as otherwise required by law.
ELIGIBILITY AND PARTICIPATION

Plan Administration
The EMI Health Vision Plan is administered and underwritten by Educators Mutual Insurance Association of Utah.

Eligibility
An Employee and his Dependents are eligible for participation and coverage under the Plan if the Employee is a Full-time Employee of the Employer. Dependents of the Employee eligible for coverage include Dependent children from birth to the 26th birthday and the Employee’s Spouse. Children may include stepchildren, children placed for adoption, legally adopted children, and children for whom the Employee has legal guardianship, (as determined by the Employer). Coverage for an adopted child of a Subscriber is provided from the moment of birth, if placement for adoption occurs within 30 days of the child’s birth, or beginning from the date of placement if placement for adoption occurs 30 days or more after the child’s birth. Coverage ends if the child is removed from placement prior to being legally adopted. A Dependent child’s coverage may be extended beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Subscriber for support and maintenance. The Subscriber must furnish written proof of disability and dependency to EMI Health within 31 days after the child reaches 26 years of age. In addition, upon application, the Plan will provide coverage for all disabled Dependents who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age of 26. EMI Health may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. (Please refer to Dependent in the “Definition of Terms” section for more information.)

Change in Member Information
Subscribers should notify EMI Health within 31 days whenever there is a change in a Member’s situation that may affect the Member’s enrollment eligibility or status.

Enrollment
To enroll, the Employee must complete an enrollment application and file it with his Employer within 31 days of his employment date or as specified by the Employer, or during a subsequent Open Enrollment period.

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 as determined by the Employer.

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.
Termination of Coverage
Unless eligible for continuation coverage under COBRA, a Member’s participation under the Plan ceases on the earliest of the following:

- For the Subscriber and covered Dependents, the date determined by the Employer regarding the Subscriber’s termination of employment or when the Subscriber’s employment position or status changes such that He is no longer a Full-time Employee;

- For the Subscriber and covered Dependents, the last day of the month for which coverage has been paid, in the event any required Subscriber contributions are not made (subject to the 30-day Grace Period);

- For covered Dependents, other than the Subscriber’s Spouse, the individual ceases to be an eligible Dependent on the last day of the calendar month coinciding with the Dependent’s 26th birthday;

- For covered Spouse, the last day of the calendar month coinciding with the date the divorce from the Subscriber is final;

- For the Subscriber and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;

- For the Subscriber and covered Dependents, the date this Plan is terminated; and

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

A Subscriber 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 Subscriber experiences a Special Enrollment qualifying event He may elect to terminate coverage for himself and/or his Dependents by making an election with the Policyholder, in the manner prescribed by the Policyholder, within 31 days of such event.
Family Medical Leave Act (FMLA)
A Subscriber who goes on a leave under the Family Medical Leave Act (FMLA) has the following rights during such leave:

- A Subscriber may continue his coverage and the coverage of his covered Dependents during an FMLA leave provided the Subscriber continues to pay any required Employee portion of the cost of coverage in accordance with the Employer’s FMLA leave policy. The Employer shall continue to make the same contributions toward that coverage that it would have made had the Subscriber not taken FMLA leave.

- If premiums are not paid, the Subscriber’s and covered Dependents’ coverage will be terminated 31 days after the due date of any required payment. Upon the Subscriber’s return to work, the Subscriber’s coverage and the coverage of any previously covered Dependents will be reinstated as long as the Subscriber returns to work before or following the expiration of the FMLA leave. If the Subscriber does not return to work before or following the expiration of the FMLA leave, the Subscriber 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 Subscriber 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 Subscriber pays any required Subscriber contribution. If the period of duty is for more than 31 days, EMI Health must permit the Subscriber to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 24 months or the period of duty. A Subscriber receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period can be imposed on a returning Subscriber and his Dependents if the period would have been satisfied had the Subscriber’s coverage not terminated due to the duty leave.

Qualified Medical Child Support Orders
Upon receipt of a National Medical Support Notice requiring the Subscriber to provide coverage for a Dependent child, EMI Health will comply with all applicable requirements of the notice and applicable law.
CONTINUATION OF COVERAGE

COBRA Continuation of Coverage Requirements
Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), a Member 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 Members 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.
COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

Coordination with Other Group Plans
When a Member 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. Refer to Plan document for full details on Coordination of Benefits with other group plans.

Internal Coordination of Benefits
Not all plans provide internal coordination of benefits. Please contact EMI Health for further details.

When a husband and wife are both eligible for group medical insurance by EMI Health as Employees of the same or different Policyholders, full coordination of benefits, not to exceed the Table of Allowances, will be extended to all eligible members of the family according to the definitions of this policy.

When a husband and wife are both covered under this policy, the primary coverage shall provide both primary and secondary liabilities under this policy after satisfying the front-end Deductible requirements of the coverage.
CLAIMS PROCEDURE

Except as otherwise provided in this policy or by Utah law, no benefits provided under this policy shall be paid to, or on behalf of, a Member unless the Member, or his authorized representative, has first submitted a written claim for benefits to EMI Health. Claims may be submitted at any time within 12 months of the date the expenses are incurred. If, however, the Member 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.

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 is for prescribed glasses or contact lenses, and there is no coded Provider bill, fill out the Employee portion of a claim form, attach the related receipts, and submit them to the above referenced address. EMI Health’s Claims Department will supply claim forms. 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 Member’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 Member or the Provider. EMI Health is likely to request information directly from the Member for the following reasons:

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

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

Exhaustion of Administrative Remedies
No action at law or in equity may be brought against EMI Health or the plan administrator, and no arbitration request may be made, until the Member has exhausted the claims review process, as provided in this policy.

Claims Review Process
If EMI Health denies payment of a claim which a Member believes is properly compensable under the applicable terms of the Plan, the Member shall within the time limits provided in subparagraphs one through five below after receipt of notice of denial of payment or coverage take the matter up with EMI Health’s claims review committee, which shall be 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. If agreement
is not reached on the claim, the Member shall within the time limits provided in subparagraphs one through five below after the decision of the claims review committee have the right to request a second level appeal regarding the disputed claim and an in-person hearing by **EMI Health board of directors**, which shall include at least one consumer representative. This request must be in writing and must be received by EMI Health, within the time limits provided in subparagraphs one through five below after receipt of notice indicating the decision of the claims review committee. The EMI Health board of directors notice of decision will inform the Member of its decision and, if adverse to the Member, the basis of its decision in writing. If the Member disagrees with the decision of the EMI Health board of directors in the second level appeal, the Member shall have a right to submit the matter to binding arbitration or to pursue any remedies available at law or equity. If the Member elects binding arbitration, then all relevant information and the positions of all parties shall be submitted to the arbitrator, who shall then review the matter and make a decision which is final and binding on EMI Health and the Member. In no event shall the arbitrator have the power to extend or expand upon the provisions of the Plan. The procedure for arbitration shall be as provided in the **Arbitration** provision of this Plan.

EMI Health will observe time limits, provide notices, and administer appeals in accordance with subparagraphs one through five below.

1. EMI Health will provide a notice of its initial claim decision within (a) 30 days after receiving the initial claim, or (b) 45 days after receiving the claim if EMI Health determines that such an extension is necessary due to matters beyond the control of the Plan and if EMI Health provides an extension notice during the initial 30-day period. If the extension is due to the Member’s failure to submit sufficient information necessary to decide a claim, the extension notice shall specify the additional required information and the Member will have at least 45 days to provide the additional information. The period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent until the date on which the Member provides the additional required information.

2. If EMI Health denies the claim in whole or in part, the Member has 180 days after receiving notice of the claim denial to appeal the decision in writing.

3. The claims review committee will provide notice of its decision on appeal within 30 days after receiving the request for appeal.

4. If the claims review committee denies the claim in whole or in part, on appeal, the Member has 180 days after receiving notice of the denial to request a second level appeal in writing.

5. The board of directors will provide notice of its decision on the second level of appeal within 30 days after receiving the notice of appeal to the board.

**Independent Review of Medical Necessity**

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

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

**Arbitration**

ANY MATTER IN DISPUTE BETWEEN YOU AND THE COMPANY MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE COMPANY. THE COMPANY SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES, AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY’S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

If, after exhaustion of the claims review process provided in this Plan, the Member still disputes the results of the same, the subject claim, controversy, or dispute may be submitted for resolution through binding arbitration in accordance with the provisions hereof.

The Member may initiate arbitration proceedings by giving written notice to EMI Health of the election to proceed with binding arbitration within 180 days after the delivery in writing of the final adjudication from the claims review process.

**Benefit Accumulations**

All Deductibles, benefit limits, etc., except for the Lifetime Maximum Benefit, accumulate on a Contract- or Calendar-Year basis. (Check with EMI Health or the Policyholder for accumulation dates.)
DEFINITION OF TERMS

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

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.

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

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

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

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

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

- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident-only coverage.
- 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 are in excess of those of any private insurance or other non-governmental plan.
- Medicare supplement policies.

The term COB Plan is construed separately with respect to each policy, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a policy, contract, or other arrangement which is subject to a Coordination of Benefits provision, as separate from the portion which is not subject to such a provision.
**Coinsurance** means the percentage of eligible charges payable by a Member directly to a Provider for covered services. Coinsurance percentages are specified on the Summary of Benefits chart.

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

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

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

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

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

**Dependent** means the Subscriber’s children (including legally adopted children and children for whom the Participant has legal guardianship, as determined by the Employer) to their 26th birthday. A child is considered a Dependent beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is dependent on the Subscriber for support and maintenance. The Subscriber must furnish proof of disability and dependency to EMI Health within 31 days after the child reaches 26 years of age. In addition, upon application, the Plan will provide coverage for all disabled Dependents who have been continuously covered with no break of more than 63 days, under any accident and health insurance since the age of 26. 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 Subscriber’s natural children, children placed for adoption, or adopted children for whom a court order or administrative order has dictated that the Subscriber provide coverage. Dependent also refers to the Subscriber’s Spouse. Dependent does not include an unborn fetus.

**Eligible Expenses** means those charges incurred by the Member 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.
- Do not exceed the EMI Health Summary of Benefits or Table of Allowances for the services performed or materials furnished.
- Are not excluded from coverage by the terms of this policy.
- Are incurred during the time the Member is covered by this policy.

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

**Employee** means a full-time Employee or an elected or appointed officer of the Policyholder. Employees must be legally entitled to work in the United States.
**Employer** means Policyholder.

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

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

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

**Experimental or Investigative** means medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

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

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

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

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

**Lifetime Maximum Benefit** means the maximum amount of benefits paid by EMI Health that will be allowed under this Plan whether accumulated under this policy or any combination of policies administered by EMI Health.

**Medically Necessary or Medical Necessity** means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is

- In accordance with generally accepted standards of medical practice in the United States;
- Clinically appropriate in terms of type, frequency, extent, site, and duration;
- Not primarily for the convenience of the patient, physician, or other health care Provider; and
- Covered under the contract.

When a medical question-of-fact exists, Medically Necessary shall include the most appropriate available supply or level of service for the individual in question, considering
potential benefits and harms to the individual, and known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established interventions, the effectiveness shall be based on Scientific Evidence, professional standards, and expert opinion.

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

**Plan** means EMI Health Vision plan.

**Policyholder** means the Policyholder as stated on the face page of the policy.

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

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

**Reliable Evidence** means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying the same drug, device, medical treatment, or procedure.

**Scientific Evidence** means 1) scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or 2) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

**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.

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

**Subrogation** means the right that EMI Health 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 EMI Health has advanced or paid to or on behalf of a Member, where such monies were paid as a result of an injury to the Member that was the fault of the third party.
**Subscriber** means the individual employed by the Policyholder and enrolled with the Plan to receive covered services, through whom Dependents may also be enrolled with the Plan. Subscribers are also Members. The term Subscriber may include eligible early retirees.

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

**Table of Allowances** means the schedule for payment of Eligible Expenses established by EMI Health.
EMI HEALTH
EDUCATORS MUTUAL INSURANCE ASSOCIATION OF UTAH
EDUCATORS HEALTH CARE
EDUCATORS HEALTH PLANS HEALTH
EDUCATORS HEALTH PLANS LIFE, ACCIDENT, AND HEALTH

NOTICE OF PRIVACY PRACTICES
Effective: July 1, 2012

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.
Section 1. Introduction

Educators Mutual Insurance Association of Utah and its affiliates listed above (“Health Plan”) are dedicated to maintaining the privacy of your health information. This Notice governs certain health insurance benefits that you may purchase from us (i.e., Medical, Dental, and Vision benefits).

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.EMI Healthmutual.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 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 may contract with business associates for certain services related to the Health Plan. PHI about you may be disclosed to these business associates so that they can perform contracted services. To protect your PHI, each business associate is required to appropriately safeguard your PHI.

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.

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:

- 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.

**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 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; (3) prior to April 14, 2003; or (4) 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
EMI Health
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 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:

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

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:

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

Contact: Privacy Officer

Telephone: Salt Lake City (801) 262-7476
Outside Salt Lake City (800) 662-5850
Outside Utah (800) 548-5264