EMI HEALTH™
Smart Benefits

2016 Medical Provider Manual

emihealth.com

Provider Manual Contents

EMI Health
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Murray, UT 84107

Administrative Lines
Local 801-262-7476
Toll free 800-662-5850
Fax 801-269-9734

Assistant Vice President
Provider Relations & Network Development
Ben Lewis
Local 801-270-2882
Toll free 800-662-5850

Preauthorization
Local 801-270-3037
Toll free 888-223-6866
Fax 801-270-3010

For durable medical equipment only:
Local 801-262-7675
Toll free 800-644-5411

Provider Assist (for questions concerning claims, benefits, NPI, or EDI)
providerassist@emihealth.com
Local 801-262-7975
Toll free 800-644-5411

Provider Listing / Website
www.emihealth.com

Urban Region

Northern Salt Lake County (north of Murray)

Lauren Ziska

Direct Line (801) 270-2950 or lziska@emihealth.com

Southern Salt Lake County (from Murray south)

Laura Lewon

Direct line 801-270-2821 or llewon@emihealth.com

Northern Region

Box Elder, Davis, Morgan and Weber Counties

Nancy Hansen

Direct Line (801) 270-2928 or nhansen@emihealth.com

Central Region

Juab, Tooele and Utah Counties

Gary Southern

Direct line 801-270-2909 or gsouthern@emihealth.com

Southern & Rural Regions

Beaver, Cache, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Iron, Kane, Millard, Piute, Rich, San Juan, Sanpete, Sevier, Summit, Uintah, Wasatch, Washington and Wayne Counties

Emily Harenberg

Direct Line (801) 270-2951 or eharenberg@emihealth.com

Provider Credentialing

Teresa Powell

Direct Line (801) 270-2824 or tpowell@emihealth.com

EMI Health

Since 1935, EMI Health has served the education community in Utah with great products and services through Educators Mutual Insurance Association (EMIA). EMIA is a non-profit company organized to provide health insurance, dental insurance, and other benefits to employees of public education, higher education, and other educational-based organizations. EMIA is the longest standing insurance provider of employee benefits for school districts.

Educators Health Plans Life, Accident, and Health, Inc. is a wholly-owned subsidiary of EMIA organized to provide a full range of insurance benefits and services to the commercial business sector.

EMI Health takes pride in providing quality, cost-efficient benefits to our insureds and excellent service to our providers. All of us at EMI Health are committed to continue providing you with the best.

To continue our long tradition of service to our members and customers by providing high quality employee benefit programs at the lowest cost.

Vision

Being a leader in providing innovative, high quality employee benefit programs recognized by their performance and value.

Values

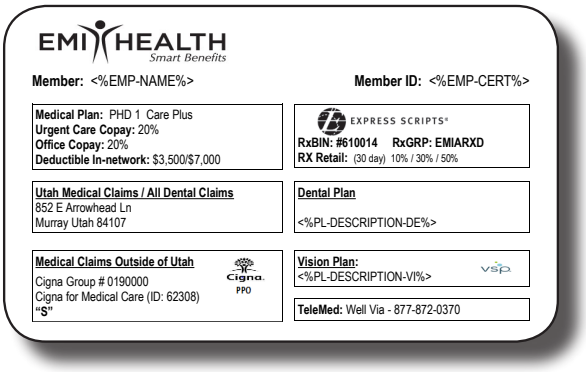
1. Members are the focus of everything we do. To achieve member satisfaction, the quality of our service is our number one priority.
2. We are a team. Employees treat each other with trust and respect. Employee involvement is our way of life.
3. Integrity is never compromised. We are honest and forthright and meet the highest ethical standards.
4. We meet our responsibility to be prudent with our resources.
5. Healthcare providers, brokers, agents, and consultants are our partners.

Overview

EMI Health Plans are designed to provide savings through the application of managed care concepts. Primary care physicians (PCP) work with their patients and specialist physicians to determine the most cost-effective way of delivering care.

Eligibility: Each patient will have a medical identification and prescription drug card indicating that he or she is participating with EMI Health. Patients are expected to present their cards at the time of service. If the patient does not present a card, please call the Provider Assist Line at 801-262-7975 or toll free at 800-644-5411 for verification of the necessary insured information. Any description given is not a certification of coverage or a guarantee of payment. All benefits are subject to the plan provisions, exclusions, and limitations. Benefit determination will be made at the time the claim is submitted. You may also check patient eligibility online with My EMI Health.

EMI Health Insureds carry identification cards that look similar this:*



*The design of the card is subject to change without notice.

Referral to Secondary Care Provider: Not required.

EAP Referral: While some plans offer Employee Assistance Programs, referrals are not required.

Covering Provider: Preferred benefits will only be paid if the covering provider is also participating with the plan's panel.

Payment: Insured pays copayment, coinsurance, and/or deductible, according to the employer group's contract at the time of service. Participating provider accepts the maximum allowable amount from EMI Health and the insured's payment as payment in full. Participating provider agrees to bill EMI Health directly.

Preauthorization: Under the Participating Provider Option, the provider is responsible for preauthorization. Under the Non-participating Provider Option, the insured is responsible. Both are accomplished through EMI Health preauthorization department. If the EMI Health Plan is secondary, preauthorization is not necessary.

Overview

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 insured. In the following pages you will find the standard preauthorization guidelines for EMI Health plans. If you have any questions concerning preauthorization, contact our Provider Assist Line. To preauthorize with EMI Health call 888-223-6866 or 801-270-3037.

The preauthorization process begins with pre-certification, or review for medical necessity. After medical necessity is determined through the Utilization Review and Case Management Unit, EMI Health finalizes the authorization by verifying patient eligibility, plan exclusions, COB information, plan maximums, etc. Upon completion, an authorization number is assigned. A letter is sent to both the provider and the insured outlining the authorization information.

If you have a patient you feel could benefit from case management, please refer this information to the EMI Health Preauthorization Department as well.

Guidelines

Whether preauthorization is required, and if so, how and when it must be obtained, depends on the kind of treatment. The following treatments require preauthorization:

- Hospitalizations and inpatient facility admissions, including skilled nursing facilities, and mental health and drug / alcohol treatment (Emergencies must be post-certified within 48 hours or as soon as reasonably possible.)
- Residential treatment
- Surgeries, in a hospital or ambulatory surgical facility
- Home health services, including home I.V. services
- Dental services, including orthodontics, when dental injury occurs as a result of an accident
- Durable medical equipment or prostheses
- Hyperbaric Oxygen Treatment
- Clinical trials
- Flight-based interfacility patient transport services when using a nonparticipating air ambulance service.

Only the primary surgical procedure, instead of each procedure performed, requires preauthorization. Please note, all procedures are subject to plan exclusions and claims edit system coding rules.

For services or treatments that require inpatient hospitalization, other than emergencies, preauthorization must be obtained at least 48 hours prior to receiving the services or treatments. For emergency hospitalizations, you must give notice of the hospitalization within 48 hours of the admission, or as soon as reasonably possible. An appropriate length of hospitalization will then be determined by EMI Health.

To obtain preauthorization for durable medical equipment or protheses submit, to EMI Health, a written request accompanied by a letter of medical necessity.

EMI Health recommends that providers submit outpatient preauthorization requests via fax; however, telephone preauthorization requests are also accepted. You can find the outpatient preauthorization form at www.emihealth.com under "Provider Forms."

Preauthorization guidelines also apply to mental health and drug / alcohol treatment. All inpatient services must be preauthorized before hospitalization and facility admissions.

If the appropriate preauthorization is not obtained in the required time, EMI Health will review the treatment and apply penalties in accordance with the Provider Participation Agreement.

If a claim is submitted without the required preauthorization, or if the claim submitted does not match the existing preauthorization information, processing may be delayed until EMI Health completes further review.

Preauthorization Review Process

If EMI Health denies a request for preauthorization based on a determination of medical necessity, which you believe is properly compensable under the applicable terms of the member's plan, you may within the time limits provided in the plan take the matter up with the EMI Health Utilization Review by calling 1-801-270-3037 or toll free 1-800-223-6866. If you disagree with the finding of the Utilization Review, you may request a second review.

If EMI Health denies a request for preauthorization based on plan benefits or eligibility, you may request a review by following the Claims Review Process on page 22.

What is the Employee Assistance Program (EAP)?

An EAP is designed to supplement the mental health and drug/alcohol treatments benefits of the medical plan by offering counseling to address such typical problem areas as marital difficulties, family problems, personal emotional difficulties, drug and alcohol problems, and other areas of stress.

How is the EAP accessed?

Not all plans have an EAP benefit. For information regarding an insured's EAP, refer to insured's medical card for information or call the Provider Assist Line (801-262-7975 or 800-644-5411) for EAP verification.

When the insured needs assistance from a mental health provider, he calls the EAP. A counselor will meet with the insured, evaluate his or her needs, and determine the most appropriate plan of action for the insured to obtain quality care. The EAP counselor may be able to help resolve the issues within a few visits or may refer the insured to a participating mental health provider. EAP referrals are not required for insureds to access the mental health benefits of their medical plans.

Please contact EMI Health to find out who the EAP consulting group is for your patient at 801-262-7975 or 800-644-5411.

Which is better - paper claims or electronic submission?
Electronic submission is the fastest, safest way to submit your claims. Electronic submission also reduces the chance of errors.

What is EMI Health's EDI Trading Partner Number?
HT000214-001

What is the mailing address for paper claim submissions?
EMI Health, 852 East Arrowhead Lane, Murray, UT 84107.

Can I send my COB (coordination of benefits) claims electronically?
Yes, EMI Health accepts COB Claims through EDI.

How do I submit a corrected claim?
When submitting corrected claims through EDI, put "7" in box 22 and your notes in box19. when submitting corrected claims on paper, mark or stamp "CORRECTED" on the claim.

How will I know if additional information is required to process my claim?
EMI Health will notify you in writing if additional information is needed to process a claim.

Why won't EMI Health accept a claim that has white-out or other markings on it?
EMI Health will not accept any claims that appear to be altered, including claims that contain white-out, crossed out marks, partial handwriting, etc. This helps to protect you against fraud.

What do I do if my Tax ID Number (TIN) has changed?
Contact your provider relations representative immediately to avoid a delay in processing your claims.

What is the timely filing deadline?
Claims must be received within 12 months of the date of service. Claims received after this deadline will be reviewed on a case-by-case basis and may be denied for untimely filing.

How long does it take my claims to get paid?
EMI Health processes clean claims within 30 days.

How do I report unlisted procedures?

Remember to always use the most specific code available. When a miscellaneous code must be used, a description of the services or supplies should be listed on the claim (in the remarks section for EDI submission).

Why do injury claims sometimes take longer to process?

There are times when information regarding how an injury or illness occurred must be requested from the insured. You can facilitate this process by forwarding any available information on how the injury occurred (e.g., auto accident) using applicable E diagnosis codes and/or remarking claims in the notes section.

Can I balance bill members if they don't pay their copays in a timely manner?

As a contracted provider, you cannot bill the member amounts above the table of allowance, with the exception of service charges and interest related to the collection of the member's copay, coinsurance, or deductible.

Who do I call if I don't agree with the way my claim was paid?

For questions on claims payment and claims appeals, contact EMI Health Provider Assist Team at 801-262-7975 or toll free at 800-644-5411.

Introduction to Optum

Optum is a healthcare information company that provides financial and clinical management solutions to payers and providers. Optum products allow all sides of health care to cost-effectively manage payment delivery.

Claims Edit Software (iCES)

iCES is a widely used expert system that assists in evaluating the accuracy of submitted CPT, HCPCS, ASA, and ICD9 / 10 codes, based on American Medical Association guidelines. It is not programmed to determine the medical necessity of a procedure. If iCES identifies inappropriate coding relationships or inappropriate line item information on medical bills, it will deny, or recommend a correction to, submitted codes. EMI Health will advise you of any changes on your Explanation of Payment (EOP).

Corrected Bills

iCES codes on the EOP will indicate if a corrected bill is necessary (Example: UF-Claims Edit System Denied. Procedure is bilateral specific, modifier required). Corrected CMS-1500 claims must be stamped or otherwise marked "Corrected Claim."

Code Review Appeals

If you wish to appeal a denied code, you must submit the claim and the medical notes, along with all supporting documentation as to why you are not billing according to the American Medical Association guidelines, addressed to the attention of Code Review Specialist. Code reviews will be conducted by EMI Health's in-house code review specialist and/or coding specialists or medical consultants, as appropriate.

Helpful Reminders

- Use modifiers when necessary with the appropriate associated CPT codes.
- New patient codes should not be used for established patients.
- Bill all charges for the same date of service on the same CMS-1500 or UB04.
- Any coding denials will be based on AMA guidelines and clinical rationale.
- You can identify an iCES code by looking at the Description of Codes on your EOP. iCES code descriptions will always begin with the words "Claims Edit System."
- Insureds are only responsible for their copayments, deductibles, and/or coinsurance to providers. There should be no balance-billing for iCES denials. There are three possible ways to respond to an iCES correction: write-off the amount in question, submit a corrected bill, or request a code review.

What is EDI?

Electronic Data Interchange (EDI) is a system of accepting claims electronically. EMI Health is an EDI partner with the Utah Health Information Network (UHIN). When submitting your claims electronically, please make sure your claims are in accordance with the national standards. For information regarding the national standards, please refer to the UHIN website at www.UHIN.com.

Why should I bill EDI?

EDI saves you money. It eliminates paper handling and requires less preparation time for staff. With EDI there are no expenses for paper or postage. Claims billed EDI have a faster processing time than paper claims. It reduces the chance of error, which improves data quality. It's HIPAA compliant. Through accept and reject reports, available within 24 hours from the time of billing, you will know whether EMI Health has received your claim.

How do I submit EDI claims?

To send claims through EDI you must work with UHIN to obtain your trading partner number. Once you've received your new trading partner number, you may begin submitting EDI claims to EMI Health's trading partner number HT000214-001. Test claims are not required.

If you have questions, call our Provider Assist Line at 801-262-7975 or toll free at 1-800-644-5411.

Providers who have already been assigned trading partner numbers can submit claims electronically to HT00214-001.

EMI Health belongs to the Utah Health Information Network (UHIN). UHIN provides health care services with reduced costs and improved access to quality healthcare through the following:

- Creating and maintaining an electronic network to link Utah's health care community to promote the electronic exchange of important financial and clinical information.
- Setting compatible standards with that of the nationally recognized standards for healthcare data and reporting, electronic interfaces, and communication services. This leads to an increase in healthcare consistency.
- Gathering and providing information to a state-wide health statistical database to help state agencies fulfill their legislatively mandated responsibilities, thereby lessening the burden of government.
- Conducting educational programs consistent with UHIN's purposes.

UHIN is the vehicle through which electronic health care data will be transmitted. EMI Health will comply with the current HIPAA transaction codes listed below:

Transaction Description	Code	Initiated by	Submitted to
Health Claim/Encounter	837	Provider	Payer
Remittance Advice	835	Payer	Provider
Eligibility	270	Provider	Payer
Eligibility	271	Payer	Provider
Claim Status	276	Provider	Payer
Claim Status	277	Payer	Provider
Attachments	275	Provider	Payer

If you have questions or would like further information regarding UHIN, please visit www.UHIN.com.

*Information courtesy of the Utah Health Information Network.

EMI HEALTH Smart Benefits

EMI Health
852 East Arrowhead Lane
Murray, Utah 84107-5211

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Patient Account #: SR62P0L2B
Patient: John Q. Public

Provider: Sally Doe
Employee: John Q. Public

Subscriber#: 24770000000
Claim #: 215-0000000000-01

Service Dates	Proc. Code	Billed	Allowed	Provider Discount	Not Covered	Reason Code	Deductible	Coinsurance	Co-pay	Payment
06/01-06/01-2015	0291	$577.00	$498.50	$78.00	$0.00	05	$0.00	$99.70	$0.00	$398.80
Column Totals		$577.00	$498.50	$78.00	$0.00		$0.00	$99.70	$0.00	$398.80

Other Insurance Credits or Adjustments	$0.00
Total Payment Amount	$398.80
Member Responsibility	$99.70

Charge
These figures represent the charges billed for the services rendered.

Allowed
This is the amount established by EMI Health as the allowable payment for those services.

Provider Discount
This represents the provider write-off.

RSN Code
These codes, which are explained at the bottom of the EOP, provide you with additional information on how the benefits for this claim were determined.

Deductible / Copay / Coinsurance
These amounts are the insured's responsibility.

Payment
EMI Health will pay this amount.

My EMI Health is an online services system that allows you to view claims, eligibility, and benefit information and access patients' Explanation of Benefits online.

Getting started with My EMI Health is easy and only takes a few minutes. Just go to www.emihealth.com, click on My EMI Health under the green LOGIN button, select Register Now, and follow the simple online instructions. If you have any questions, please call our Provider Assist line at 801-262-7975 locally or toll free at 1-800-644-5411.

While you are on our website, sign up to receive EMI Health's quarterly Medical Provider Newsletter via email. Just click on the Newsletter Quick Link in the gray box.

We also offer electronic funds transfer (EFT) as a payment option. In order to enroll in this method of payment, you must be receiving electronic remittance advices (ERA or 835) from EMI Health through UHIN. For more information, contact your provider relations representative.

Claims Review Process

If EMI Health denies payment of a claim, in whole or in part, that you believe is properly compensable under the terms of the patient's policy, and that denial is not based on a coding issue, you may request a review of that claim decision as follows.

1. Send a written request for review to the attention of EMI Health Claims Review Committee within 180 days after receiving notice of the decision. Please include all pertinent information regarding the claim and explain your reasons for believing the claim should have been granted. You should also include any additional information that will aid the Claims Review Committee in reviewing the claim. You will be notified in writing of the Claims Review Committee's decision. If the previous decision on payment of the claim stands, in whole or in part, you will be given a specific reason for the decision.

2. If you do not agree with the findings of the Claims Review Committee, in whole or in part, you 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 within 180 days after the date of the letter indicating the decision of the Claims Review Committee. The EMI Health Board of Directors will inform you of its decision and the basis of that decision.

Code Review Process

If EMI Health denies payment of a claim, in whole or in part, based on coding issues, you may request a code review as follows. (Coding adjustments will typically be identified on your EOP with the words "Claims edit system deny.")

1. Send a written request for code review to the attention of Code Review Specialist within 60 days after receiving notice of the decision. Please include all pertinent information regarding the claim, including copies of all medical notes, and explain your reasons for believing the claim should have been granted as coded. You should also include any additional information that will aid the Code Review Specialist in reviewing the claim. You will be notified in writing of the Code Review Specialist's decision. If the previous decision on payment of the claim stands, in whole or in part, you will be given a specific reason for the decision.

2. If you do not agree with the findings of the Code Review Specialist, in whole or in part, you may request a second review of the disputed codes. This request must be in writing and must be received by EMI Health within 30 days after the date of the letter indicating the initial decision of the Code Review Specialist. Second reviews will be submitted to outside coding specialists or medical consultants, as appropriate. The Code Review Specialist will inform you in writing of the results of the second review.

What is the billing process?

To avoid claim processing delays, each billing must be completed with all the required information (see below). We prefer that you send your claims through Electronic Data Interchange (EDI). To send claims electronically you must obtain a trading partner number from UHIN. (See page 17.)

What information is required on my CMS 1500?

Please refer to the CMS standards for information regarding what is required on your claim form. If you are not using EDI, your office staff must use the CMS 1500 universal claim forms. EMI Health will not accept super bills.

How will it be paid?

The claim will be paid according to the policyholder's contract and the EMI Health Table of Allowance.

What portion is the insured responsible for paying?

The insured pays the difference between the allowable charge and the amount EMI Health pays. If the provider is participating, any balance in excess of the EMI Health Table of Allowance will be adjusted by the provider. The insured's responsibility will be outlined in your explanation of payment under the Deductible, Coinsurance and Co-pay columns.

Patient Account #: SR62P0L2B
Patient: John Q. Public

Provider: Sally Doe
Employee: John Q. Public

Subscriber#: 24770000000
Claim #: 215-0000000000-01

Service Dates	Proc. Code	Billed	Allowed	Provider Discount	Not Covered	Reason Code	Deductible	Coinsurance	Co-pay	Payment
06/01-06/01-2015	0291	$577.00	$498.50	$78.00	$0.00	05	$0.00	$99.70	$0.00	$398.80
Column Totals		$577.00	$498.50	$78.00	$0.00		$0.00	$99.70	$0.00	$398.80

Other Insurance Credits or Adjustments	$0.00
Total Payment Amount	$398.80
Member Responsibility	$99.70

Example:
$577.00 is submitted and $498.50 is allowed. EMI Health pays $398.80.
The insured pays $99.70 coinsurance, and the provider writes off $78.50.

What if I disagree with the way my claim is paid?

You may request a review of any claim decision by following the claims review procedure on page 21.

To which providers and facilities may I refer my patients?

EMI Health's insureds will receive maximum benefits, with less out-of-pocket expense, when they are referred to participating providers. Please remember to refer EMI Health insureds to Intermountain Healthcare or other participating facilities. You may access the most up-to-date provider listing on our website at www.emihealth.com.

Do I need a National Provider Identifier (NPI)?

The Federal government requires that all providers have an NPI, whether you submit claims electronically or on paper. In order to ensure smooth claims processing, if you have not already submitted your NPI to EMI Health, you may fax it to 801-270-3076 or call the Provider Assist line at 801-262-7475 or 800-644-5411.

What if I do not receive my electronic funds transfer (EFT) or electronic remittance advice (835) transaction?

It normally takes between 24-48 business hours from the payment cycle to the receipt of your 835 and EFT payment. Under the Affordable Care Act Operating Rule 370, section 4.3, late or missing is defined as a maximum elapsed time of four business days following the receipt of either the EFT or the 835.

Missing 835

If you are missing a remittance, please use the following procedures:

1. Contact UHIN with the transaction number and date processed. They will also need your trading partner number and the NPI for the provider.
    - UHIN Help Desk Toll-Free: 877-693-3071
    - UHIN Help Desk Salt Lake City Area: 801-716-5901
2. The file will be sent if the issue concerns matching the NPI to the trading partner.
3. If UHIN does not have information for your request, they will forward the information to EMI Health.
4. The EDI support team at EMI Health will respond with an email within 24 business hours of the request.
5. EMI Health will research the transaction to obtain the file name to repost.
6. An email will be sent when the file has been resent.

Missing EFT

If you are missing the EFT, please follow the directions below:

1. Contact EMI Health's accounting department at 801-270-2972 with the missing transaction number and the date it was processed.
2. EMI Health will research the transaction to obtain the routing number and account number to which the money was sent and to see if the EFT transaction was returned.
3. EMI Health will contact you to verify whether the routing number and account number are correct.
4. EMI Health will resend the EFT transaction to the corrected routing number and account number.
5. You will receive an email notifying you when the re-sent EFT transaction will be deposited into your bank account.

The Express Scripts Physician Service Center is available to EMI Health Providers. It is a toll-free help line dedicated to physicians and their office staffs nationwide, staffed with experienced customer service representatives and pharmacists. Representatives are available 8 a.m. to 8 p.m. Eastern Standard Time, Monday through Friday.

The current capabilities of the Express Scripts Physician Service Center include the following:

- Written correspondence / Physician Urgent Cases
- General Questions or Concerns
- Health Management (Therapy Optimization)
- Drug Information
- Expediting Prescription Handling
- Troubleshooting Fax Issues
- Point of Care Calls (Electronic Prescribing)

You may reach the Express Scripts Physician Service Center toll free at 1-800-211-1456.

Many complex medical conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatiod arthritis, are treated with specialty medications. Whether they are administered by a healthcare professional, self -injected, or taken orally, specialty medications require an enhanced level of service. In addition, specialty medications are typically bio-engineered and have specific shipping and handling requirements or are to be dispensed by a specific facility.

EMI Health has partnered with Accredo, Express Script's primary specialty pharmacy, to assist in dispensing most specialty drugs. Receiving the specialty drug from Accredo will help assure that our insureds pay the lowest cost and receive the best service possible.

Accredo deals exclusively with specialty medications and offers the following services:

- Toll-free access to specially trained pharmacists 24 hours a day, seven days a week.
- Personalized counseling from a dedicated team of registered nurses and pharmacists.
- Expedited, scheduled delivery of medications at no additional charge.
- Refill reminders.
- Necessary supplies, such as needles and syringes, provided with the medications.

Many EMI Health plans now require that certain specialty medications previously obtained directly from a pharmacy, a home infusion company, or the doctor's office be obtained through Accredo in order to receive coverage.

You can help your patient get started with Accredo by calling toll-free 1-800-803-2523 between 6:00 a.m. and 6:00 p.m. Mountain Standard Time, Monday through Friday. You will need the EMI Health member number located on the patient's ID card.

As is standard in the industry, EMI Health reduces the allowed amount on claims for multiple or bilateral surgeries performed during the same operative session.

When multiple or bilateral surgical procedures (CPT range 10000 to 69999), with the exception of add-on and exempt codes, are performed during the same operative session, and are billed without modifiers, EMI Health reduces the allowed amount and processes as follows:

	Primary Procedure	Additional Procedures
% of Table of Allowances	100%	50%

Multiple or bilateral procedures for Co-Surgeons and Assistant Surgeons are processed as follows:

		Primary Procedure	Additional Procedures
% of Table of Allowances	Co-Surgeons Modifier 62	62.5%	31.25%
	Assistant Surgeon Modifer 80	20%	10%
	Minimal Assist Modifier 81	20%	10%

When procedures are billed with modifiers, the following rules apply:

Modifier	Description	Table of Allowances Percent of
50	Bilateral	150%
51	Multiple	50%

Please note that all procedures are subject to plan exclusions and claims edit system coding rules.

You may contact the Provider Assist Line at 801-262-7975 or toll free 800-664-5411 with any questions.

EMI Health respects the confidentiality and privacy of protected health information.

Without inhibiting access or efficiency, we are committed to protecting all protected health information we receive - whether orally, electronically, or by mail. Under federal law and a regulation issued by the Utah Insurance Department, EMI Health is required to inform individual customers of EMI Health's policies and practices regarding the collection, disclosure, and privacy of the nonpublic personal information of EMI Health's customers, including their nonpublic personal financial information and their nonpublic personal health information. A complete notice of EMI Health's privacy policies and practices is available at www.emihealth.com.

Any disclosure of personal health information will be made in compliance with HIPAA regulations, on a need to know basis, and will consist of the least amount of information required to perform the function. In order to comply with state and federal laws and to protect the privacy of our insureds, provider assist representatives need to verify your identity before they can give you any information. You will be required to give the representative your Tax ID and individual NPI numbers. You will then be required to verify the patient's identity by providing the insured's social security number or EMI Health identification number, the patient's name, and the patient's birth date. If this information is not available, EMI Health will be unable to disclose any information, because we cannot verify the patient's identity.

Once your identity and the identity of the insured have been verified, EMI Health can disclose the following information:

- Benefit information
- Billed amount, allowed amount, and paid amount
- Description of service/CPT code
- Copayment, coinsurance, and/or deductible amount

- Verification of ICD 10 code
- Claims payment status or date claim was paid
- Type of service
- Provider of service
- Date of service

In addition, the following information may be disclosed in regards to a preauthorization:

- Authorization number and status
- Referring physician
- Length of stay (inpatient hospital)
- Provider of service
- Authorized days / visits

When a patient is covered by EMI Health 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 EMI Health's plan is secondary, EMI Health will calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that amount to any allowable expense under the EMI Health 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. EMI Health will credit to the deductible any amounts that would have been credited to the deductible in the absence of other healthcare coverage.

EMI Health 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 EMI Health's plan is the primary plan, EMI Health will pay or provide its benefits on a primary basis.
- If EMI Health's 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 EMI Health's 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, EMI Health will adjust any payments accordingly.
- If the Non-conforming Plan reduces its benefits so that the insured 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 insured 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.
- In consideration of such advance, EMI Health shall be subrogated to all rights of the insured 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 EMI Health's plan have been made under any other COB plan, 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 EMI Health will be fully discharged from liability to the extent of the payment.

If any payment exceeds the maximum amount necessary to satisfy this provision, 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 insured, 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 insured.
- The provider, whether Participating or Non-Participating, limited to a time period of 36 months from the date a payment was made unless the reversal is due to fraudulent acts or statements or the intentional misrepresentation of a material fact by the insured.
- Any other insurance companies.
- Any other organization.

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 EMI Health's plan. However, when all available no-fault auto medical insurance benefits have been paid, EMI Health will pay according to its normal schedule of benefits. If the insured does not have proper no-fault insurance and is involved in an accident, no benefits will be paid until the minimum no-fault auto medical benefits have been paid by the insured, his or her dependent, or a third party.

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

Sample Plan Document Definitions

Accident or **Accidental Injury**, for which benefits are provided, means Accidental bodily Injury sustained by the Insured 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 benefits provided by the plan that are available only if specific medical criteria, established by EMI Health are met. The portion the Insured pays for these benefits may 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.

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

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:

- 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 means the entity selected by the Policyholder to administer COBRA benefits. See Policyholder for COBRA Administrator contact information.

Coinsurance means the percentage of eligible charges payable by an Insured 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 Insured has satisfied any applicable Deductible and paid Eligible Expenses, including Copayments, up to the Coinsurance Maximum, EMI Health will pay remaining Eligible Expenses at 100% of the Table of Allowances, up to the per person Lifetime Maximum Benefit, for the remainder of that 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.

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 an Insured is responsible to pay directly to a Provider. Copayment amounts are specified on the "Summary of Benefits" chart.

Custodial Care means maintenance of an Insured 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.

Deductible means the amount paid by an Insured for Eligible Expenses from the Insured'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 Subscriber's children (including stepchildren, legally adopted children, and children for whom the Participant has legal guardianship) to their 26th birthday. A child is considered a Dependent beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is dependent on the 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.

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.
- 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
- Generally is not useful to a person in the absence of Illness or injury.
- Is appropriate for use in the home.
- Is Medically Necessary.

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, any home, van, or other vehicle modifications, and/or improvements are not covered benefits.

Eligible Expenses means those charges incurred by the Insured 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 and the lesser of the Table of Allowances or Usual and Customary fees for the services performed or materials furnished.
- When more than one treatment is available, and one option is no more effective than another, the Eligible Expense shalll be for the least costly option that is no less effective than any other option.

- Are not excluded from coverage by the terms of this Plan.
- Are incurred during the time the Insured 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 or her 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 or Educators Health Plans Life, Accident, and Health, Inc.

Employee means a Full-time Employee or an elected or appointed officer of 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.

ERISA Plan means a plan that is subject to the Employee Retirement Income Security Act of 1974, as amended.

Exclusion means the Plan 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, 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.

- These Experimental or Investigative methods are not yet accepted as an approved or standard of care diagnosis or treatment by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, 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 authorative, 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 an Active Employee of the Employer; an Employee is considered to be Full-time if he or she normally works at least the number of hours per week designated by the Employer and is on the regular payroll of the Employer for that work.

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

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.

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

Home Health / Skilled Nursing Care means medical care and treatment rendered to a sick or injured Insured in the Insured's home, when the Insured 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 order and general supervision of the Insured'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.

Insured means an Employee or Dependent who enrolled with EMI Health to receive covered services and who is recognized by EMI Health as an Insured. Employees/retirees of the Policyholder who are eligible to become Insureds can choose to enroll Dependents who satisfy EMI Health's Dependent eligibility requirements. In situations requiring consent, payment, or some other action, references to "Insured" include the parent or guardian of a minor or disabled Insured on behalf of that Insured.

Intensive Care Room means a Hospital section, ward, or wing that operates exclusively for critically ill Insureds 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 or her 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 Insured's life or cause permanent damage to his or her 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. 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 Members and may change without prior notice to Members.

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

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 amount;
3. The actual billed charges for the covered services.

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

The Maximum Allowable Charge will not include 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 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.

Modalities means any physical agent applied to produce therapeutic changes to biologic tissue; including but not limited to thermal, acoustic, light, mechanical, or electric energy.

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

Non-ERISA Plan means a plan that is not subject to the Employee Retirement Income Security Act of 1974, as amended.

Non-participating Provider means a health care practitioner operating within the scope of his or her 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.

Open Enrollment means the period, as defined by the Policyholder, during which an Employee may apply for insurance coverage for himself or herself or his or her Dependents.

Out-of-area Dependent means a child who does not reside with the parent who is responsible for providing health insurance coverage required by a court or administrative order and does not reside in the plan's service area.

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

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

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

Plan means EMI Health Care Plus Plan.

Plan Year means the 12-month period beginning on the effective date.

Policyholder means Employer.

Post-service Health Claim means any claim for a benefit under the Plan that involves only the payment or reimbursement of the cost for medical care that has already been provided.

Preauthorization (Pre-service Claim) means the procedure a Provider and/or Insured 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 an Insured 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 or father 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 or her 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.

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.

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

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 Infertility means a condition where a person has been able to conceive or father a child at least once.

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 Year, rather than waiting for the next Open Enrollment period, if he or she has experienced a qualifying event (including marriage, divorce, birth, adoption, placement for adoption, loss of other insurance coverage, or approval to receive a Premium Assistance.) under HIPAA or ERISA regulations. The Subscriber must complete a new enrollment form and submit it to the Policyholder within 31 days of any change in coverage or status.

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 an Insured, where such monies were paid as a result of an injury to the Insured that was the fault of the third party.

Subscriber means the individual employed by the Policyholder through whom Dependents may be enrolled with the Plan. Subscribers are also Insureds.

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 of covered services established by EMI Health.

Therapeutic Procedures means a manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

Total Disability or **Totally Disabled** means the inability of a Subscriber to perform his or her regular occupation. Subscribers 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.)

Urgent Preauthorization Request means a request for Preauthorization (Pre-service Claim) of medical care or treatment, if the application of the time periods for making non-urgent determinations (1) could seriously jeopardize the claimant's life, health, or ability to regain maximum function, or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization request. The determination of whether a request is an Urgent Preauthorization Request will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. A request will be treated as an Urgent Preauthorization Request if a physician with knowledge of the claimant's medical condition determines it to be one.

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 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 Plan Participant 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.

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Smart Benefits

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