2017 Dental Provider Manual

emihealth.com

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Local 801-262-7975
Toll free 800-644-5411

Provider Listing / Website
www.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.

Together, they are EMI Health. EMI Health takes pride in providing quality, cost-efficient benefits to our insureds and excellent service to our providers. We 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.

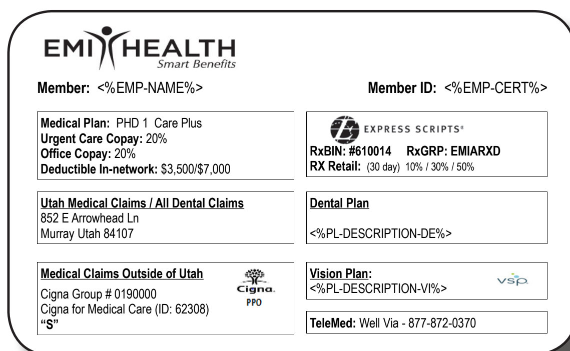
Overview

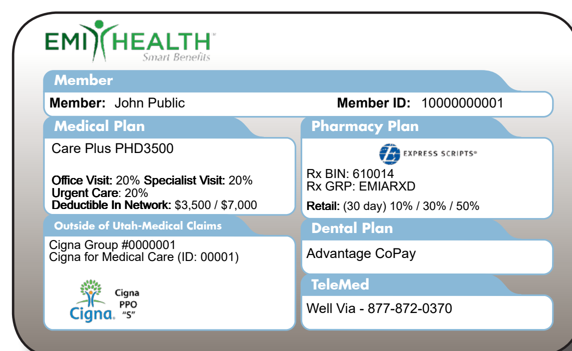
EMI Health Plans are designed to provide our members with the highest quality services with the lowest reasonable premiums.

Insured Identification: Each patient will have an identification 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. You may also check patient eligibility online with My EMI Health.

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.

EMI Health insureds carry identification cards that look similar to one of these:*





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

Premier

The Premier Dental Plans offer the highest level of coverage. Employer groups are given the opportunity to customize their benefits to suit their needs. Therefore, you may see varied benefits that affect the member's out-of-pocket expenses. Feel free to contact our Provider Assist line for information on patients' benefits, or look them up online through My EMI Health.

Choice

The Choice Dental Plan provides members with the option of a richer benefit when using the Advantage network, as well as the flexibility to use the broader Premier network. Under the Choice Dental Plan, the Advantage network takes precedence over the Premier network. Dentists who participate in both networks will be reimbursed according to the Advantage Plus fee schedule, based on the richer Advantage Plus benefits of the Choice Dental Plan design. Patients will typically take advantage of the richer Advantage Plus benefits to receive more dental benefits throughout the year, since their out-of-pocket expenses will be less.

Advantage

The Advantage Dental Plan offers the option of excellent coverage with a lower premium. Advantage Copay is offered as a standard plan, with benefits the same between employer groups. Many preventive services are covered 100 percent by EMI Health, and there are no waiting periods or annual maximums. The participating provider panel is smaller and more exclusive on Advantage, allowing a participating provider the benefit of in-network referrals.

Value

The Value Dental Discount Program offers the option of discounts for a minimal premium. EMI Health's Value Plan is offered alongside the Advantage and Premier Plans. Your office accepts the full allowed amount listed on the fee schedule from the patient as payment in full.

Predetermination of benefits

Before starting major dental treatment for which the charge is expected to be $300 or more, a predetermination of benefits is recommended. To obtain a predetermination, the dentist must itemize all recommended services and costs and attach all supporting documents, including x-rays. EMI Health will notify your office of the benefits payable under the plan. The insured and the dentist can then decide on the course of treatment, knowing in advance how much the plan will pay.Predetermination is not required for basic services, such as fillings and x-rays.

Please note that this information is subject to change without prior notification.

We would prefer that you process your claims through EDI, but we will accept paper ADA claim forms from those providers who are not already submitting electronic claims. We will no longer accept any paper ADA claims from providers who are submitting electronic claims, unless the claim is a corrected claim or a claim with accompanying office notes and other required documentation. Paper claims must be computer generated or typed. Handwritten claims are not accepted.

- When submitting a corrected ADA claim, indicate "corrected" by stamping it on the claim. EMI Health will not accept any claims that may appear to be altered (i.e., claims with white-out or crossed out marks). This helps us protect you against fraud.

- EMI Health will notify you in writing when additional information is required to process a claim. Documentation may be sent along with a paper claim to speed up processing time when additional information is required for accident details or corrected claims.

Remember to 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.

If your Tax ID changes, contact EMI Health for the required forms prior to submitting claims with the new Tax ID.

Claims must be received by EMI Health within 12 months from the date of service. Claims past this timeline will be reviewed on a case-by-case basis. EMI Health may deny an untimely claim.

What is Electronic Data Interchange?

Electronic Data Interchange (EDI) is a system of accepting claims electronically.

Why should I bill EDI?

EDI saves you time and 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.

How do I get started?

If you are not yet set up to submit claims through EDI, you will need to obtain a trading partner number from the Utah Health Information Network (UHIN.) Once you've received that number, you may begin immediately submitting EDI claims to EMI Health's trading partner number HT000214-001. Test claims are not required. EMI Health also works with all of the major clearinghouses, including Apex and Emdeon. Be sure to mention your association with EMI Health, as Apex offers a discount to all EMI Health providers.

For information about, changes to, or concerns with EDI that you may have, please contact EMI Health's Provider Assistance at 801-262-7975 or toll free at 800-644-5411.

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

- Creating and maintaining an electronic network to link Utah's healthcare 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 healthcare data will be transmitted. UHIN is EMI Health's only direct connection at this time. 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 their website at www.UHIN.com.

*Information courtesy of the Utah Health Information Network.

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, 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 the time specified on the explanation of payment. 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 the time specified in 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.

What is the billing process?

To avoid claim processing delays, each billing must be completed with all the required information. We prefer that you send your claims through Electronic Data Interchange (EDI).

Claims billed through Electronic Data Interchange (EDI) have a faster processing time than paper claims, and there is a reduced chance of error. If you are not yet set up to submit claims through EDI, you will need to obtain a trading partner number from the Utah Health Information Network (UHIN). Once you've received that number, you may begin immediately submitting EDI claims to EMI Health's trading partner number HT000214-001. Test claims are not required.

EMI Health also works with all of the major clearinghouses, including Apex and Emdeon. Be sure to mention your association with EMI Health, as Apex offers a discount to all EMI Health providers. If EDI submission is not an option for your office at this time, using the most current ADA claim form will help ensure that your claims are accurately processed.

What information is required on my claim?

Please refer to the ADA standards for information regarding what is required on your claim form. If you are not using EDI, you must use the most current standard ADA claim form.

How will it be paid?

The claim will be paid according to the policyholder's contract and the EMI Health Plan 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. These amounts will be outlined on your explanation of payment.

Patient Account #: SR62P0L2B
Patient: John Q. Public

Provider: Sally Doe
Employee: John Q. Public

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

Service Dates	Proc. Code	Tooth #	Billed	Allowed	Provider Discount	Not Covered	Reason Code	Deductible	Coinsurance	Co-pay	Payment
06/01-06/01-2015	D2392	3	$200.00	$92.00	$108.00	$0.00	05	$0.00	$18.40	$0.00	$73.60
06/01-06/01-2015	D2391	15	$150.00	$75.00	$75.00	$0.00	05	$0.00	$15.00	$0.00	$60.00
	Column Totals		$350.00	$167.00	$183.00	$0.00		$0.00	$33.40	$0.00	$133.60

Other Insurance Credits or Adjustments	$0.00
Total Payment Amount	$133.60
Member Responsibility	$33.40

Do I need to accept the Table of Allowance (fee schedule) for services that exceed the member's plan maximums?

According to the terms of your agreement with EMI Health, insureds will be charged the lesser of (1) provider's fee for services; or (2) EMI Health's fee schedule. This includes, without limitation,services rendered to insureds that exceed the number or quantity of services authorized under the plan, such as a second examination when only a single examination is authorized, and services rendered after the insured's annual maximum benefit amount has been reached, and orthodontics and related services, whether or not those services are a benefit of the insured's plan.

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.

To which providers 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. 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 individual Type I 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 can fax the completed form to the Provider Assist department at 801-269-9734. If you have questions about NPI, call EMI Health's Provider Assistance at 801-262-7975 or toll free at 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 transaction will be deposited into your bank account.

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	Tooth #	Billed	Allowed	Provider Discount	Not Covered	Reason Code	Deductible	Coinsurance	Co-pay	Payment
06/01-06/01-2015	D2392	3	$200.00	$92.00	$108.00	$0.00	05	$0.00	$18.40	$0.00	$73.60
06/01-06/01-2015	D2391	15	$150.00	$75.00	$75.00	$0.00	05	$0.00	$15.00	$0.00	$60.00
		Column Totals	$350.00	$167.00	$183.00	$0.00		$0.00	$33.40	$0.00	$133.60

Other Insurance Credits or Adjustments	$0.00
Total Payment Amount	$133.60
Member Responsibility	$33.40

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

Provider Discount
This represents the provider write-off.

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

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

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.

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 Dental 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.

Orthodontic coverage varies for each employer group. Please feel free to contact Provider Assist to verify benefits for an individual or employer group.

EMI Health makes annual payments for orthodontics, based on the treatment plan. For example:

- If the treatment is expected to take one year or less, EMI Health will make one payment covering all of the eligible charges.
- If the treatment is expected to take between 13 and 24 months, EMI Health will make two annual payments for 50 percent of the eligible charges.
- If the treatment is expected to take between 25 and 36 months, EMI Health will make three annual payments for 33.3 percent of the eligible charges.
- If a patient discontinues coverage with EMI Health at any point during the treatment, no further payments will be made. Any additional expenses would be the responsibility of the patient or new carrier.

Please be certain to submit the total charges on one claim and include the treatment plan information.

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 a 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 customers, including their nonpublic personal financial information and their nonpublic personal health information. A complete notice of EMI Health 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
- Description of service/ADA code
- Date of service
- Provider of service
- Billed amount, allowed amount, and paid amount
- Copayment, coinsurance, and/or deductible amount
- Claims payment status or date claim was paid

When a patient is covered by an EMI Health plan and another COB plan, one plan is designated as the primary plan. The primary plan pays first and ignores benefits payable under the other plan. The secondary plan reduces its benefits by those payable under the primary plan.

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

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

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

When EMI Health's plan is secondary, EMI Health will calculate the benefits the plan would have paid on the claim in the absence of other healthcare coverage and apply that amount to any allowable expense under the plan that is unpaid by the primary plan. Payment will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all COB plans for the claim do not exceed 100 percent of the allowable expense for that claim. 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 is the primary plan, EMI Health will pay or provide its benefits on a primary basis.

- If EMI Health 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:

- The Insured, limted to a time period of 18 months from the date a payment is made.

- The Provider, whether Participating or Non-Participating;

    - Limited to a time period of 36 months from the date a payment is made for a COB claim involving Meicare, Medicaid, or CHIP.

    - Limted to a time period of 24 months from the date of a payment is made fror any other COB claim.

- 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 and 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 Insured that a reasonable person would perceive to be a threat of bodily harm.

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

Adverse Benefit Determination means any of the following:

1. A denial in benefits,
2. A reduction in benefits;
3. A 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.

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.

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

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

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

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

- 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.
- Group-type contracts.
- Medical care components of long-term care contracts, such as skilled nursing care.
- 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 policy, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a policy, contract, or other arrangement which is subject to a Coordination of Benefits provision, as separate from the portion which is not subject to such a provision.

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

COBRA Administrator means the entity selected by the Policyholder to administer COBRA benefits.

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.

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

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

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

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 policy.

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

Dependent means the 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.

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.
- When more than one treatment is available, and one option is no more effective than another, the Eligible Expense shall be

- Do not exceed the EMI Health Summary of Benefits and the Maximum Allowable Charge 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 Insured is covered by this policy.

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 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.

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.

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

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

Insured means an eligible person who enrolled with EMI Health through the Employer to receive covered services and who is recognized by EMI Health as an Insured. Employees / retirees of the Employer 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.

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

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

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

Medically Necessary or Medical Necessity means 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 Providers; 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.

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

Policyholder means Employer.

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

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

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

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.

Special Enrollment means the right of an individual to enroll during the plan year, rather than waiting for the next Open Enrollment period, if he has experienced a qualifying event (including marriage, divorce, birth, adoption, placement for adoption, loss of other insurance coverage, or approval to receive a Premium Assistance) under HIPAA or ERISA regulations. The Subscriber must complete a new enrollment form and submit it to EMI Health 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 and enrolled with the Plan to receive covered services, through whom Dependents may also be enrolled with the Plan. Subscribers are also Insureds. 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 covered services established by EMI Health.

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