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## INTRODUCTION

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

Your health and dental benefits and Educators' administrative procedures are described in this handbook. You are urged to read it carefully, share its contents with the members of your family, and keep it for future reference. If you have any questions or need further information, contact your employer or the Educators Customer Service Department.

**This handbook is a summary only;** it is not a contract. The Plan Document is available for your review from your employer during regular business hours.

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

Regardless of benefits specified, this plan will reimburse or pay any claim only if the services rendered are determined to be medically necessary. Determination of medical necessity is made by Educators using its own set of criteria, or by an independent contractor appointed by Educators.

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

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

If you need more information on any of the Weber State University plans or procedures, please call an Educators Customer Service Representative between 8:00 a.m. and 5:00 p.m., Monday through Friday (MT):

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

### **Plan Administrator**

The Educators Care Plus plan is underwritten by Educators Health Care and the Dental plan is underwritten by Weber State University. Both plans are administered by Educators Mutual Insurance Association of Utah.

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# Educators Health Care

**Administered by Educators Mutual Insurance Association of Utah**

Administration ..... 262-7476 • 1-800-662-5850

Customer Service ..... 262-7475 • 1-800-662-5851

**PLEASE NOTE: All services are subject to Educators Table of Allowances. When using a Non-participating Provider, the Member is responsible for all fees in excess of the Table of Allowances.**

Weber State University Summary of Benefits July 1, 2006 - June 30, 2007	Educators Care Plus	
	Participating Provider Option	Non-participating Provider Option
<b>GENERAL INFORMATION</b>	<b>YOU PAY</b>	
Lifetime Maximum Benefit	\$1,000,000	
Preexisting Condition Window Period	6 months prior	
Preexisting Condition Waiting Period	First 10 months of coverage / 18 months Late Enrollees	
Dependent Age Limit	26	
Coinsurance Maximum (Per Person/Family Per Plan Year - Separate from and not satisfied by the Mental Health or the Prescription Coinsurance Maximum)	\$1,200 / \$2,400	\$1,200 / \$2,400
First Dollar Deductible (Per Person/Family Per Plan Year - Separate from and not satisfied by Mental Health Deductible)	*\$400 / *\$1,200	*\$400 / *\$1,200
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
Non-Precertification EAP Penalty	Not Applicable	
<b>PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic is available, member pays the copay plus the difference between the generic and the brand price)</b>	<b>YOU PAY</b>	
Coinsurance Maximum (Per Family Per Plan Year)	*\$1,250	
Participating Pharmacy (30 day supply)	20% Generic (\$5 Min) / 25% Preferred (\$10 Min) / 35% Non-Preferred (\$20 Min)	
Non-Participating Pharmacy (30 day supply)	20% Generic (\$5 Min) / 25% Preferred (\$10 Min) / 35% Non-Preferred (\$20 Min) Member pays in full at time of purchase, then files for reimbursement	
Significant Medication (during first 12 months after FDA approval)	*50%	
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	
Mail Order (90 day supply)	20% Generic (\$5 Min) / 25% Preferred (\$10 Min) / 35% Non-Preferred (\$20 Min)	
<b>HOSPITAL/FACILITY BENEFITS (Physician and Professional Services are not included in this section.)</b>	<b>YOU PAY</b>	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	◆ 5%	◆ 20%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	◆ 5%	◆ 20%
Skilled Nursing Facility (60 days per Confinement) (Admission must be within 5 days of discharge from Hospital Confinement)	◆ 5%	◆ 20%
Medical/Surgical Care (Outpatient)	◆ 5%	◆ 20%
Emergency Room (ER)	*\$100	*\$65 then 20%
Major Diagnostic Test (per test of \$300 or more)	◆ 5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Inpatient) (per test less than \$300)	5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Outpatient) (per test less than \$300)	5%	◆ 20%
InstaCare Clinic	*\$35	◆ 20%
<b>REHABILITATION THERAPY BENEFIT</b>	<b>YOU PAY</b>	
Inpatient – physical, speech, occupational, cardiac or pulmonary (\$5,000 per person per Plan year)	◆ 5%	◆ 20%
<b>ACCIDENT AND LIFE THREATENING ILLNESS</b>	<b>YOU PAY</b>	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit subject to the Table of Allowance
Ambulance Land/Air (Accident & Life-threatening)	*\$65	
Orthodontic Injury Treatment (\$500 per occurrence)	◆ *50%	◆ *50%
Dental Injury Treatment	◆ 20%	◆ 20%
<b>PHYSICIAN &amp; PROFESSIONAL SERVICES</b>	<b>YOU PAY</b>	
Physician Office Visits (primary care)	*\$20	◆ 20%
Physician Office Visits (secondary care)	*\$30	◆ 20%
Physician Office Visits (after hours)	*\$30	◆ 20%
Physician Visits (Inpatient)	◆ 5%	◆ 20%

Services designated "\*" do not accumulate toward your Coinsurance Maximum.

Services designated "◆" are subject to first dollar Deductible.

Weber State University Summary of Benefits July 1, 2006 - June 30, 2007	Educators Care Plus	
	Participating Provider Option	Non-participating Provider Option
Physician Visits (Outpatient)	Covered 100%	◆ 20%
Major Diagnostic Test (office) (per test of \$300 or more)	◆ 5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (office) (per test less than \$300)	Covered 100%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Inpatient) (per test less than \$300)	5%	◆ 20%
Minor Diagnostic Test, X-ray, Lab (Outpatient) (per test less than \$300)	5%	◆ 20%
Radiology/Pathology (office)	Covered 100%	◆ 20%
Radiology/Pathology (Inpatient)	5%	◆ 20%
Radiology/Pathology (Outpatient)	5%	◆ 20%
Injections (with office visit)	Covered 100% (after copay)	◆ 20%
Surgery (office)	*\$20	◆ 20%
Surgery (Inpatient)	◆ 10%	◆ 20%
Surgery (Outpatient)	◆ 10%	◆ 20%
Anesthesiology (office)	Covered 100%	◆ 20%
Anesthesiology (Inpatient)	5%	◆ 20%
Anesthesiology (Outpatient)	5%	◆ 20%
Routine Prenatal & Delivery (Dependent maternity included)	5%	◆ 20%
Home Health Care (in lieu of Hospital)(for supplies, see Medical Supplies and Equipment)	◆ 5%	◆ 20%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac or pulmonary - 20 visits per Plan year - Preauthorization required after first 5 visits)	*\$20	◆ 20%
Chiropractic Therapy (20 visits per Plan year, Preauthorization required after first 5 visits)	*50% (CHP)	◆ *50%
Allergy/Serum	*\$15 per vial	◆ 20%
Allergy Injections (with office visit)	Covered 100% (after copay)	◆ 20%
<b>NEWBORN BENEFITS AT DELIVERY</b>	<b>YOU PAY</b>	
Medical/Surgical/Intensive Care/Newborn Complications (semi-private room)	5%	20%
Medical/Surgical/Intensive Care/Newborn Complications (Inpatient Ancillary)	5%	20%
Physician Visits (Inpatient)	5%	20%
Surgery (Inpatient)	10%	20%
Radiology/Pathology (Inpatient)	5%	20%
Anesthesiology (Inpatient)	5%	20%
<b>PREVENTIVE SERVICES</b>	<b>YOU PAY</b>	
Routine Physical Exam (1 visit per Plan Year)	Covered 100%	Not Covered
Routine Gynecological Exam (1 visit per Plan Year)	Covered 100%	Not Covered
Family History Exam (1 visit per Plan Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (per evaluation schedule)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Child Immunizations (per evaluation schedule)	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Plan Year)	*\$20	Not Covered
Routine Hearing Exam (1 visit per Plan Year)	*\$20	Not Covered
<b>TRANSPLANT BENEFIT (\$100,000 lifetime combined maximum)</b>	<b>YOU PAY</b>	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
<b>MEDICAL SUPPLIES &amp; EQUIPMENT</b>	<b>YOU PAY</b>	
Medical Supplies	◆ 20%	◆ 20%
Medical Supplies (office)	Covered 100%	◆ 20%
Durable Medical Equipment/Prosthesis	◆ 20%	◆ 20%
Orthotic Supplies (\$200 per Plan year)	◆ 20%	◆ 20%
Growth Hormone (\$8,000 per lifetime)	◆ 20%	◆ 20%
<b>DENTAL BENEFITS</b>	<b>YOU PAY</b>	
Impacted Teeth/Cysts/Tumors	Covered on Dental Plan	

Services designated "\*" do not accumulate toward your Coinsurance Maximum.

Services designated "◆" are subject to first dollar Deductible.

Weber State University Summary of Benefits July 1, 2006 - June 30, 2007	Educators Care Plus	
	Participating Provider Option	Non-participating Provider Option
<b>MENTAL HEALTH &amp; DRUG/ALCOHOL TREATMENT</b>	<b>YOU PAY</b>	
Coinsurance Maximum (Per Person/Family Per Plan Year - Separate from and not satisfied by Medical Coinsurance Maximum)	\$1,200 / \$2,400	\$1,200 / \$2,400
First Dollar Deductible (Per Person/Family Per Plan Year - Separate from and not satisfied by Medical Deductible)	*\$400 / *\$1,200	*\$400 / *\$1,200
Inpatient Facility Semi-private Room	◆ *\$50 per day	◆ *\$50 per day then *50%
Inpatient Facility Ancillary	◆ 5%	◆ *50%
Inpatient Facility Physician Visits	◆ 5%	◆ *50%
Physician Office Visits Psychologist/Clinical Social Worker/APRN/Psychiatrist	*\$25	◆ *50%
<b>OTHER LIMITED BENEFITS</b>	<b>YOU PAY</b>	
Adoption Indemnity Benefit (\$4,000 per adoption)	◆ 5%	
TMJ Syndrome diagnosis & non-surgical treatment (\$500 per lifetime)	◆ *50%	◆ *50%
Orthognathic/Mandibular Osteotomy (\$2,500 per lifetime)	◆ *50%	◆ *50%
Total Parenteral Nutrition (\$10,000 per Plan year)	◆ *50%	◆ *50%
Significant Medication (during first 12 months after FDA approval)	*50%	◆ *50%
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	◆ *50%
Primary Infertility (\$1,500 per Plan year, \$5,000 per lifetime)	◆ *50%	Not Covered

PLEASE NOTE: This is a **summary only** and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in this contract.

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## ELIGIBILITY AND PARTICIPATION

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### Plan Administration

The Educators Care Plus plan is administered by Educators Mutual Insurance Association of Utah and underwritten by Educators Health Care.

### Eligibility

An Employee of Weber State University (hereinafter WSU) and his Dependents are eligible for participation and coverage under this Plan if the Employee is a Full-time Employee of WSU or Early Retiree. Dependents of the Employee eligible for coverage include unmarried Dependent children from birth to the 26<sup>th</sup> birthday and the Employee's Spouse. Unmarried children may include stepchildren, children legally placed for adoption, and legally adopted children. Coverage for an adopted child of a Subscriber is provided from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth. Coverage ends if the child is removed from placement prior to being legally adopted. A Dependent child's coverage may be extended beyond the 26<sup>th</sup> birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Subscriber for support and maintenance. In addition, upon application, the Plan will provide coverage for all unmarried 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. The Subscriber must furnish written proof of disability and dependency to the Policyholder and Educators within 31 days after the child reaches 26 years of age. Educators may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. (Please refer to *Dependent* in the "Definition of Terms" section for more information.)

### Out-of-Area Dependent

When a Subscriber or Subscriber's Spouse is required by court order, Qualified Medical Support Order (QMSO), National Medical Support Notice (NMSN), or other administrative order to provide health insurance coverage for a Dependent child, Educators will not deny enrollment of the child on the grounds that the child does not reside with the Subscriber or within the Educators service area. The Subscriber must provide proof of court order, QMSO, NMSN, or administratively-ordered coverage. At the time of enrollment, the Dependent child's state of residence must be established. The custodial parent must abide by all terms and conditions of the Plan. Preauthorization must be obtained for those services that are listed in the *Care Plus Preauthorization Requirements* section of this Plan. Payment to Non-participating Providers will be based on Eligible Expenses. The Member will be responsible for any difference between billed charges and Eligible Expenses in addition to the applicable Copayments, Coinsurance, and/or Deductible.

### Changes in Member Information

Subscribers should notify Educators within 31 days whenever there is a change in a Member's situation that may affect the Member's enrollment eligibility or status.

### Enrollment

To enroll, the Employee must complete an enrollment application and file it with WSU within 31 days of his or her employment date, or during a subsequent Open Enrollment

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period. Generally, a Subscriber is not entitled to change his or her coverage elections during the Plan Year, except as provided in the *Special Enrollment* section.

New Enrollees are subject to a 10-month Preexisting Condition Limitation, and Late Enrollees are subject to an 18-month Preexisting Condition Limitation (see *Preexisting Condition Limitation* section). The Preexisting Condition period may be reduced in whole or in part upon submission by the Member of a certificate of Creditable Coverage from the Member's former group or individual health plan. (See the *Waiver of Preexisting Condition Exclusion* section.)

### **When Coverage Begins**

If the Employee enrolls within 31 days of his or her employment, the Employee's coverage (and the coverage of his or her eligible Dependents, if such Dependents were also enrolled during such 31-day period) becomes effective on the date of hire.

If the Employee enrolls during an Open Enrollment period that is more than 31 days after his or her date of hire, the Employee's coverage (and the coverage of eligible Dependents, if such Dependents were also enrolled during such Open Enrollment period) becomes effective the first day of the following Plan Year.

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

### **Special Enrollment**

#### **Special Enrollment Period When Other Coverage Terminates**

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

1. Had COBRA continuation coverage under another plan and such continuation coverage has since been exhausted; or
2. If the other coverage was not under COBRA, either the other coverage has been terminated as a result of loss of eligibility of coverage or employer contributions towards such coverage have been terminated. (**Note:** Loss of eligibility of coverage includes a loss due to legal separation, divorce, death, termination of employment, reduction in hours worked, reaching the Lifetime Maximum Benefit, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or intentional misrepresentation.)

If the Employee meets the above conditions, he or she may elect coverage for himself or herself and/or his or her eligible Dependents by making an election with WSU, in the

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manner prescribed by WSU, within 31 days of such cessation. If the Employee makes a timely election, coverage will be effective as of the date such coverage ceased.

### **Special Enrollment Period for Acquisition of Dependent**

The Employee and/or his or her new eligible Dependent may enroll for coverage (even if he or she previously declined coverage for himself or herself and/or his or her eligible Dependents) if the Employee acquires such new eligible Dependent due to marriage (including children of the new spouse), birth, adoption, or placement for adoption. In addition, the Employee may also enroll his or her Dependent Spouse if the Employee acquires a new Dependent due to marriage, birth, adoption, or placement for adoption. To enroll during this Special Enrollment period, the Employee must enroll as follows:

1. In the case of marriage, within 30 days of the event.
2. In the case of an eligible Dependent's birth, adoption, or placement for adoption,
  - a. If no additional premium is required to provide coverage for the child, the Subscriber should notify Educators of the birth or placement as soon as possible. The Subscriber must notify Educators of the birth or placement within 30 days of the date Educators mails notice of the first denied claim for the child.
  - b. If payment of additional premium is required, the Subscriber must enroll the Dependent and pay the applicable premium within 30 days of the birth or placement in order for coverage to extend beyond that 30-day period.

Coverage for the newly acquired Dependent will be effective as follows:

1. In the case of marriage, the marriage date; or
2. In the case of an eligible Dependent's birth, adoption, or placement for adoption, the date of such birth, adoption, or placement for adoption.

### **Preexisting Condition Limitation**

No benefit will be provided under this Plan for injury or Illness that was diagnosed or treated within six months before the Enrollment Date of coverage under this Plan, until the Member has been covered by this Plan for 10 months (or 18 months for Late Enrollees), unless such period is reduced in the *Waiver of Preexisting Condition Exclusion* section.

The Preexisting Condition Limitation Exclusion does not apply in the following cases:

- Pregnancy.
- Children who are covered under Creditable Coverage as of the last day of the 30-day period beginning on the date of birth, provided that this provision does not apply to a child after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.
- Adopted children who are adopted or placed for adoption before attaining 18 years of age and who are covered under Creditable Coverage as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, provided that this

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provision does not apply to an adopted child after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

No benefit will be provided for the following injuries and Illnesses during the first eight months of coverage under this Plan, unless reduced by the *Waiver of Preexisting Condition Exclusion* provision of this Plan:

- Tympanoplasty
- Tympanostomy
- Tonsillectomy
- Myringotomy
- Adenoidectomy
- Warts
- Moles
- Acne
- Lesions
- Mouth and external cysts
- Nasal septal repair
- Elective sterilization

### **Waiver of Preexisting Condition Exclusion**

The Preexisting Condition Limitation period explained above may be reduced for a Member by the aggregate of the periods during which the Member was covered under Creditable Coverage prior to enrollment in this Plan, except that a Member is not entitled to a reduction of the Preexisting Condition Limitation period for a period of Creditable Coverage if, after such period and before the effective date of coverage under this Plan, the Member experienced a break in coverage of 63 days or more, during all of which the individual was not covered under any Creditable Coverage. The Preexisting Condition Limitation period is the time Members must wait after enrolling in the Plan before they can be covered for a condition that was diagnosed or treated within six months prior to enrolling.

To obtain a reduction of the Preexisting Condition Limitation period, Members must provide Educators with certification that they have met the preexisting period through prior Creditable Coverage. This certification should be obtained from the Member's prior health plan or insurance carrier. Educators will assist Members in obtaining a certificate of Creditable Coverage from a prior plan or insurer. Members also have the right to demonstrate Creditable Coverage through documentation other than a certificate of

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Creditable Coverage, such as an explanation of Benefits (EOB) or other correspondence from a plan or insurer indicating prior coverage or a health insurance card. Members must cooperate fully with Educators to verify prior Creditable Coverage.

Members who have questions regarding these rights should contact the Educators Enrollment Department or the San Francisco Department of Labor Office, San Francisco Regional Office, 71 Stevenson St., Ste. 915, P.O. Box 190250, San Francisco, CA., 94119-0250, or call 1-866-444-3272.

Within a reasonable period following receipt of information regarding a Member's prior Creditable Coverage, Educators will do the following:

- Inform the Member of its determination of Creditable Coverage and how it will be recognized towards any Preexisting Condition Limitation period;
- Notify the Member in writing of its determination of any Preexisting Condition Limitation period;
- Explain the basis for the determination and the information on which Educators relied in making the determination;
- Allow the Member the opportunity to appeal the determination and submit additional evidence of Creditable Coverage. (See the *Claims Review Process* section.)

If Educators subsequently determines that the Member did not have the claimed Creditable Coverage, Educators may modify its initial determination if notice of the reconsideration is provided in writing to the Member and, until the final determination is made, Educators acts in a manner consistent with the initial determination for purposes of approving access to medical services.

### **Termination of Coverage**

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

- For the Subscriber and covered Dependents, the date of the Subscriber's termination of employment or when the Subscriber's employment position or status changes such that he or she is no longer a Full-time Employee, except in the case of Early Retirees;
- The Subscriber and covered Dependents, the last day of the month for which coverage has been paid, subject to a 30-day Grace Period, in the event any required Subscriber contributions are not made;
- For covered Dependents, other than the Subscriber's Spouse, the individual ceases to be an eligible Dependent when either of the following occurs:
  - a. The date the Dependent is married; or
  - b. The last day of the calendar month coinciding with the Dependent's 26<sup>th</sup> birthday;
- For covered Spouse, the date the divorce from the Subscriber is final;

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- For the Subscriber and covered Dependents, the effective date of any election by the Subscriber to cease coverage for the Subscriber and/or his or her Dependents;
  - For the Subscriber and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
  - For the Subscriber and covered Dependents, the date this Plan is terminated; or
  - For any Member, the discovery of fraud or intentional material misrepresentation of a material fact on the part of the Member in either the enrollment process or in the use of services or facilities under the terms of the coverage. (Note: If a Member's coverage is terminated under this provision based on fraud, the termination of coverage will relate back to the effective date of coverage and Educators may recover any overpayments from the Member such that Educators and the Member are returned to the same financial position as if no coverage had ever been in force. If a Member's coverage is terminated under this provision based on intentional material misrepresentation, the termination of coverage will relate back to the date the misrepresentation occurred and Educators may recover any overpayments from the Member. Termination of a Subscriber's coverage for cause will also result in the termination of coverage of the Subscriber's covered Dependents.)

### **Conversion Rights**

Members who are no longer eligible for coverage under this group Plan may be eligible to obtain medical coverage under the conversion plan in effect at the time of ineligibility. This applies only to Members who have been continuously covered under the group Plan for at least six months.

If coverage under the group Plan is terminated due to the Member's failure to pay Subscriber premiums or Copayments, performance of an act or practice that constitutes fraud, or intentional misrepresentation of material fact under the terms of the coverage, the Member may not be eligible for the conversion plan. A Member who acquires coverage through another group plan that covers all Pre-existing Conditions is not eligible for the conversion plan.

Educators will notify terminated Subscribers in writing, and shall also notify covered Dependents through Subscribers, of the availability, terms, and conditions of conversion plan coverage. Members must make application for the conversion plan and pay the applicable premium no later than 60 days after termination of group coverage.

### **Family Medical Leave Act (FMLA)**

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

- A Subscriber may continue his or her coverage and the coverage of his or her covered Dependents during an FMLA leave provided he or she continues to pay any required Employee portion of the cost of coverage in accordance with WSU's FMLA leave policy. WSU will continue to make the same contributions toward that coverage that it would have made had the Subscriber not taken FMLA leave.

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- If the Employee portion of the cost of coverage is not paid, the Subscriber's and covered Dependents' coverage will be terminated 31 days after the due date of any required payment. Upon the Subscriber's return to work, the Subscriber's coverage and the coverage of any previously covered Dependents, without additional waiting period or Preexisting Condition Limitation period, will be reinstated as long as the Subscriber returns to work before or following the expiration of the FMLA leave. If the Subscriber does not return to work before or following the expiration of the FMLA leave, the Subscriber will be treated as a new Employee upon his or her return and will be entitled to elect coverage for himself or herself and his or her eligible Dependents in accordance with the rules applicable to new Employees.

### **Military Leave**

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), a Subscriber who is on military duty with a uniformed service has certain rights. If the period of duty is less than 31 days, coverage will be maintained if the Subscriber pays any required Subscriber contribution. If the period of duty is for more than 31 days, WSU must permit the Subscriber to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 18 months or the period of duty. A Subscriber receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period or Preexisting Condition Limitation exclusion can be imposed on a returning Subscriber and his or her Dependents if the period or exclusion would have been satisfied had the Subscriber's coverage not terminated due to the duty leave.

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

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

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

If a Subscriber becomes eligible for Medicare solely as a result of attaining age 65, the Subscriber will have the option of electing coverage under this Plan, in which case this Plan is primary and Medicare is secondary. Alternatively, the Subscriber may elect to terminate coverage under this Plan and choose Medicare as his or her primary coverage. If a Subscriber chooses Medicare as his or her primary plan, the Subscriber may not elect this Plan as his or her secondary plan. Any eligible Dependents will follow the Subscriber's election regarding Medicare participation.

Contact WSU or the Educators Enrollment Department for information.

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## CARE PLUS MEDICAL PLAN BENEFITS

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### Using the Care Plus Benefits

Members should always carry their Educators Care Plus Medical Identification / Prescription Drug Cards so that Participating Providers can determine what the Member is required to pay, how to bill the Plan, and when to preauthorize major services.

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

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

- **Advantages of Using Participating Providers.** When Members elect to use Participating Providers, they enjoy the following advantages over Non-participating Providers:
  - The Provider bills the Plan for them;
  - The Provider accepts the Plan’s Table of Allowance and agrees not to bill Members for amounts in excess of the Table of Allowances for covered services; and
  - The Provider agrees to obtain Preauthorization from Educators for Members when such Preauthorization is required.
- Members should verify their Providers’ panel status at the time of each visit by following these steps:

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- Contact Providers to assure that they are Participating Providers with Educators.
  - Contact Educators Customer Service Department.

The Table of Allowances is the schedule established by Educators, for payment of eligible charges. **All benefits outlined in this Plan are subject to the Table of Allowances. For example, if a Provider charges \$125 for a procedure for which the Table of Allowances permits \$100 payment, Educators will pay the specified percentage of \$100, not \$125. If the Provider is a Participating Provider, the Member's responsibility would be the difference between the amount paid by Educators and \$100. If the Provider is a Non-participating Provider, the Member's responsibility would be the difference between the amount paid by Educators and \$125.**

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

Participating Provider Option benefits are available when the care is provided through a Participating Provider. Although Non-participating Provider Option benefits offer Members the flexibility to use any Non-participating Provider or facility, a higher payment may be required from the Member.

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

- **Using Non-participating Providers and Facilities.** When the Member elects to use Non-participating Providers and facilities
  - The Member must obtain Preauthorization from Educators for services listed in the *Preauthorization Requirements* section.
  - The benefits may be less, and in some cases, there may be no benefits available under the Non-participating Provider Option.
  - The Member is responsible for any charges exceeding the Plan's Table of Allowance for covered services.

Even in the unlikely event that there is no Participating Provider available to perform the services needed, (e.g. unusual or infrequently used health services), Educators will not pay Participating Provider Option benefits to a Non-participating Provider. Non-participating Provider Option benefits will apply.

### **Coinsurance Maximum**

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

When a Member receives any service or treatment specified as a limited benefit, Educators will pay for services only up to the specified limits.

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Any payment made by the Member for amounts in excess of the specified percentage, day, or dollar limits, and expenses the Member pays if He does not follow Preauthorization procedures, will not accumulate toward the annual Deductible or Coinsurance Maximum.

The Prescription Drugs and the Mental Health and Drug/Alcohol Treatment benefits each have separate Coinsurance Maximums that are not satisfied by the Medical Coinsurance Maximum.

### **Lifetime Maximum Benefit**

All Eligible Expenses paid by Educators whether accumulated under this Policy or any combination of plans and policies administered by Educators accumulate toward a Lifetime Maximum Benefit of \$1,000,000 per Member. Up to \$1,000 incurred toward the Lifetime Maximum Benefit will automatically be reinstated each year until the Lifetime Maximum Benefit has been exhausted.

There is one Lifetime Maximum Benefit shared by both the Participating Provider and Non-participating Provider Options.

### **Benefit Accumulations**

All Deductibles, Coinsurance Maximums, benefit limits, etc., except for the Lifetime Maximum Benefit, accumulate on a Plan Year basis, beginning July 1, and ending June 30.

### **Care Plus Preauthorization Requirements**

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

#### **▪ The following kinds of treatments require Preauthorization:**

- Hospitalizations and Inpatient facility admissions, including skilled nursing facilities
- Surgeries, in a Hospital or ambulatory surgical facility (This does not apply to diagnostic endoscopy procedures.)
- Home Health services, including home I.V. services
- Dental services, including orthodontics, when dental injury occurs as a result of an Accident
- Hernia-related procedures
- Dayspring/Day Treatment
- Prevnar (covered up to age 23 months, with Preauthorization)
- Durable Medical Equipment and Prostheses costing more than \$300 (see *Medical Supplies and Equipment*)

- **If the Member uses a Participating Provider, for any of the above treatments or procedures, the Provider (not the Member) is responsible for Preauthorization. The Member is advised to verify with the physician that Preauthorization procedures have been followed.**

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- **If the Member uses a Non-participating Provider** for any of the above treatments or procedures, **the Member (even in an emergency) is responsible for obtaining Preauthorization, and benefits may be denied or reduced if the Member fails to timely obtain Preauthorization, as follows:**
    - To obtain Preauthorization for Durable Medical Equipment or Prostheses submit, to Educators, a written request accompanied by a letter of Medical Necessity.
    - To obtain Preauthorization for all other services, call 1-801-270-3037 or (toll free) 1-888-223-6866.
    - For services or treatments that require Inpatient hospitalization, other than emergencies, the Member, or a designated family member, must obtain Preauthorization at least 48 hours prior to receiving the services or treatments, or as soon as reasonably possible.
    - **For emergency hospitalizations, the Member, or a designated family member, must give notice of the hospitalization within 48 hours of the admission,** or as soon as reasonably possible, by calling one of the phone numbers listed above. An appropriate length of hospitalization will then be determined.
    - If a Member responsible for obtaining Preauthorization fails to do so in the required time, Educators will review the treatment and apply the following penalties:
      - If the treatment is deemed not Medically Necessary, benefits will be denied.
      - If the treatment is deemed Medically Necessary, benefits will be reduced by 50% (per admission for Inpatient hospitalization, or per service or procedure, for the others listed above).
      - Any amount paid out-of-pocket for failing to follow Preauthorization requirements is not applied toward the Coinsurance Maximum.
  - **Mental Health and Drug/Alcohol Treatment Preauthorization.** All Inpatient services and those received from a Day Spring / day treatment facility must be preauthorized before hospitalization or facility admissions, by calling 1-801-270-3037 or (toll free) 1-888-223-6866. For emergency hospitalizations, the Member, or a designated family member, must give notice of the hospitalization within 48 hours of admission, or as soon as reasonably possible. If Preauthorization is not obtained, benefits will be denied.

### **Preauthorization Review Process**

If the Claims Administrator denies a request for Preauthorization based on a determination of Medical Necessity, which a Member believes is properly compensable under the applicable terms of the Plan, the Member may within the time limits provided below after receipt of notice of denial of Preauthorization take the matter up with the Plan's Utilization Review by calling 1-801-270-3037 or toll free 1-888-223-6866. If the Member disagrees with the finding of the Plan's Utilization Review, he or she may request a second review.

If the Claims Administrator denies a request for Preauthorization based on Plan benefits or eligibility, which a Member believes is properly compensable under the applicable terms of the Plan, the Member may within the time limits provided below after receipt of notice of denial of Preauthorization take the matter up with Educators Claims Review Committee. If the Member disagrees with the finding of the Claims Review Committee, He may request a second review and an in-person hearing by Educators Board of Directors.

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If the Member disagrees with the decision of the Plan's Utilization Review or Educators Board of Directors after the second level appeal, the Member shall have a right to submit the matter to binding arbitration or to pursue any remedies available at law or equity. If the Member elects binding arbitration, then all relevant information and the positions of all parties shall be submitted to the arbitrator, who shall then review the matter and make a decision which is final and binding on Educators and the Member. In no event shall the arbitrator have the power to extend or expand upon the provisions of the Plan. The procedure for arbitration shall be as provided in the *Arbitration* provision of this Plan.

No action at law or in equity may be brought against Educators and no arbitration request may be made until the Member has exhausted the Preauthorization Review Process, as provided in this section.

**1. Urgent Preauthorization Requests.** The following time limits and rules regarding modes of communication shall apply to Urgent Preauthorization Requests:

(a) If the Member fails to follow the proper procedures for Preauthorization, Educators will notify the Member of the failure and the proper procedures within 24 hours after the failure. The notice may be given orally unless the Member requests written notice.

(b) If the Member submits an incomplete Preauthorization request, Educators will provide notice that the request is incomplete and of the missing information within 24 hours after receiving the incomplete request. The notice may be given orally unless the Member requests written notice. The Member will have 48 hours after receiving notice of the incomplete request to provide the additional required information, which may be provided by telephone, fax, or similar method.

(c) Educators will then provide notice of its initial decision on the Preauthorization request within (1) 48 hours after receiving the completed request or after the expiration of the Member's 48-hour period to provide additional information, whichever is earlier, or (2) 72 hours after receiving the initial request, if it was proper and complete when submitted. The notice may be made orally if written or electronic notice is provided within three days after oral notification.

(d) If the Preauthorization is denied in whole or part, the Member has 180 days after receiving the Preauthorization denial to request an appeal of the decision. The request and any additional information to support the appeal may be provided by telephone, fax, or similar method.

(e) Educators will provide its decision on appeal within 72 hours after receiving the request for appeal.

**2. Non-urgent Preauthorization Requests.** The following time limits and modes of communication shall apply to non-urgent Preauthorization requests:

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(a) If the Member fails to follow the procedures for Preauthorization, Educators will notify the Member of the failure and the proper procedures within five days after the failure. The notice may be given orally unless the Member requests written notice.

(b) Educators will provide notice of its decision on the Preauthorization request within (1) 15 days after receiving initial request, or (2) 30 days after receiving the request, if Educators determines that an extension is necessary due to matters beyond its control and Educators provides an extension notice during the initial 15-day period. If the extension is due to the Member's failure to submit information necessary to decide a Preauthorization request, the extension notice will identify the additional information necessary for Educators to decide the request, and the Member will have at least 45 days from the date of such notice to provide the additional information. The period for making the benefit determination will be tolled from the date on which the notification of the extension is sent until the date on which the Member provides the additional required information.

(c) If the Preauthorization is denied in whole or in part, the Member has 180 days after receiving the Preauthorization denial to request a first level appeal of the decision. The request and any additional information to support the appeal must be made in writing.

(d) Educators will provide its decision on the first level appeal within 15 days after receiving the request for appeal.

(e) If the Preauthorization is denied in whole or in part on the first level appeal, the Member has 180 days after receiving the decision to request a second level appeal. The request and any additional information to support the appeal must be made in writing.

(f) Educators will provide its decision on the second level appeal within 15 days after receiving the request for appeal.

## **Second Opinion**

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

## **Inform Educators Care Plus of Changes**

The Subscriber may call Educators Enrollment Department or submit an Enrollment Application to notify Educators of a change in his address or telephone number. The Subscriber must use the Enrollment Application to make other changes, such as changes to name and/or marital status, as well as to add or delete family members to the Plan. Enrollment Applications are submitted to WSU. (See the *Eligibility and Participation*

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section for guidelines on adding new Dependents.) WSU will forward copies of all Enrollment Applications to Educators.

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## COVERED MEDICAL BENEFITS

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

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### **Hospital/Facility Benefits**

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

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

- Semi-private room and intensive care charges.
- Hospital ancillary charges, including operating room, dressings and supplies, and Hospital Outpatient Services rendered in connection with surgery for which the operating room and other Hospital facilities are needed. Hospital ancillary charges include, but are not limited to, the following:
  - Drugs
  - Operating room
  - Medical Supplies
  - X-ray and laboratory expenses
  - Electrocardiograms
  - Chemotherapy or radiation therapy
  - Inhalation therapy
  - Intravenous therapy
- Skilled nursing facility services, up to a maximum of 60 days per Confinement. Admission to a skilled nursing facility must occur within five days of a discharge from a Hospital Confinement.
- Outpatient surgery facility expenses. Some procedures require Preauthorization. Please refer to the list of procedures under the *Preauthorization Requirement* section.
- Diagnostic Testing.
- Eligible covered medication which is to be taken by, or administered to, an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

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

The Plan provides benefits for the following:

- Medically Necessary ER services (as defined under “Emergency Care” in the Plan) are covered according to the “Summary of Benefits” chart.
- Although payment of the ER Copayment/Coinsurance amount is not required before service may be provided in the ER, it is the Member’s responsibility to pay the ER Copayment/Coinsurance listed on the “Summary of Benefits” chart directly to the providing facility.
- The ER Copayment/Coinsurance covers the facility charges only. The Member may have additional physician and professional charges according to the “Summary of Benefits” chart.

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

## **Inpatient Rehabilitation Therapy Benefit**

The Plan provides benefits for all services and treatments in connection with Inpatient rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary). Inpatient benefits are limited to a combined maximum of \$5,000 per person per year.

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

The Plan provides benefits for the following:

- Expenses for Accidental Injuries. Accidental Injury benefits apply when treatment commences within 48 hours of the Accidental Injury and such treatment is completed within 12 months, unless a delay in treatment is Medically Necessary, or it was not reasonably possible to obtain the necessary medical treatment within 48 hours. If a delay in treatment is necessary, the Member must receive prior approval for coverage of the treatment from the Plan.
- Expenses for Life-threatening Conditions.
- Services provided by a licensed ambulance service for necessary transportation to and from a Hospital, doctor’s office, clinic, or other medical institution when the Member’s condition is deemed to be a Life-threatening Condition.
- Orthodontic treatment necessary due to an Accident, limited to \$500 per occurrence. Accidental Injury benefits apply when treatment commences within 48 hours of the Accidental Injury and is completed within 12 months, unless a delay in treatment is Medically Necessary, or it was not reasonably possible to obtain the necessary medical treatment within 48 hours. If a delay in treatment is necessary, the Member must receive prior approval for coverage of the treatment from the Plan.

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## Physician and Professional Services

The Plan provides benefits for the following:

- Physician office visits and after-hours physician office visits.
- Inpatient Hospital physician visits.
- Routine prenatal physician visits and delivery expenses. This includes visits and delivery for the pregnancy of a Dependent maternity. A Member may choose to deliver on an outpatient basis. The length of a Hospital stay after a delivery is based on Medical Necessity, except that Educators may not restrict benefits for any Hospital stay in connection with childbirth for a mother or newborn child for less than 48 hours following a normal vaginal delivery, or for less than 96 hours following a cesarean section, and may not require that a Provider obtain authorization from Educators for prescribing a length of stay not in excess of the above periods. The mother or the newborn child's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours or 96 hours, as applicable.
- Surgical and anesthetic procedures include the following:
  - Multiple or bilateral surgical procedures.
  - Surgical procedures rendered during Inpatient hospitalization, as an outpatient, or in a physician's office.
  - Treatment of fractures or dislocations and orthopedic casting.
  - Operative and major diagnostic endoscopic procedures.
  - Therapeutic surgical injections and aspirations, biopsies, and destruction of lesions by chemical, mechanical, or electrical means.
  - Operative and curative procedures rendered by a podiatrist for the treatment of diseases of the feet.
  - Surgical and anesthetic benefits cover expenses incurred for medical treatment rendered on the date of any surgical procedure or during a reasonable convalescent period following any surgery.
  - Physiological conditions such as anesthetic complications, myocardial infarction, venous thrombosis, or anaphylactic reaction, that result from corrective procedures that are not directly related to a previous Reconstructive, Cosmetic, or Plastic Surgery; other than Reconstructive Surgery performed as a result of a mastectomy or treatment of physical complications at any stage of the mastectomy, including lymphedemas.
  - Upper lid blepharoplasty when the following conditions are met:
    - Interference with vision or visual field related activities. Must have a 30 percent or lower obstruction of the superior part demonstrated before and after manual elevation of the eyelids.
    - Chronic eyelid dermatitis due to redundant skin
    - Difficulty wearing prosthesis
    - Marginal reflex distance of 2.5 mm or less
    - Palpebral fissure height on down-gaze of 1 mm or less
    - The presence of Herring's effect meeting either a marginal reflex distance of 2.5 mm or less or palpebral fissure height on down-gaze of 1 mm or less

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

- Benefits for the primary surgeon performing a surgical procedure. Pre-operative and post-operative services within the global period of the surgical procedure are included in the allowable surgeon's fee.
- Benefits for an assistant surgeon, only when Medically Necessary.
- Benefits for a co-surgeon in the absence of an assistant surgeon, in cases where two surgeons are involved in the same procedure, and if both sets of operative notes indicate the use of co-surgeons.
- Expenses for an anesthesiologist, CRNA, or nurse anesthetist.
- Laboratory and X-ray charges.
- Home Health/Skilled Nursing Care, including charges of a qualified licensed practitioner for approved private duty nursing. Certain Injectables that may be provided by a Home Health/Skilled Nursing practitioner are covered only under the Prescription Card. See the "Prescription Drug Program" for details.
- Rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary) must be given to improve the physical capabilities of a Member in an attempt to restore the individual to a previous level of good health. (Outpatient benefits limited to a maximum of 20 visits per person per Plan year for all therapies combined. Preauthorization is required after the first five visits)
- Chiropractic adjustments of the vertebral column and its immediate articulations, up to a maximum of 20 visits per person per Plan year, limited to two eligible modalities and/or therapeutic procedures per visit. (Preauthorization is required after the first five visits.) **Participating Provider Option benefits are available when using a Chiropractic Health Plan (CHP) Provider.**
- Allergy testing.
- Allergy injections and serum.
- Chemotherapeutic medications, including administration.
- Hemophiliac medications.
- Unit dose packaging of prescription drug products, including but not limited to, Factor VIII.

**Preventive Care Services**

The Plan provides benefits for the following:

- One Routine Physical Examination per person per Plan Year.

- One Routine Gynecological Examination per person per Plan Year.
- One family history examination per person per Plan Year.
- One Routine Hearing Exam per person per Plan Year.
- One Routine Vision Exam per person per Plan Year.
- Prevnar, up to age 23 months (Preauthorization required).
- Other services as outlined in the following *Evaluation Schedule Guidelines*:

**Evaluation Schedule Guidelines**

*Immunizations for Children*

	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	24 mo	4-6 yr	11-12 yr	13-18 yr.
Hepatitis B	HepB #1	HepB #2			HepB #3			Or Catch-up HepB Series				
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP			DTaP	Td	Or Catch-up Td
Haemophilus Influenzae Type b			Hib	Hib	Hib	Hib						
Inactivated Poliovirus			IPV	IPV	IPV					IPV		
Measles, Mumps, Rubella						MMR#1				MMR#2	Or Catch-up MMR#2	
Varicella						Varicella			Or Catch-up Varicella			
Pneumococcal			PCV	PCV	PCV	PCV			PPV			
Influenza						Influenza (Yearly)						
Hepatitis A						Hepatitis A Series						

*Immunizations for Adults*

<b>Disease</b>	<b>Service</b>
Rubella	One for adults without verification of live vaccine on or after their first birthday, or lab evidence of immunity
Diphtheria/ Tetanus (DT)	Booster every ten years
Measles	One for adults born after 1956 without verification of live measles vaccine on or after their first birthday, medical diagnosis of measles, or lab evidence of immunity
Influenza	Annual for over age 65 or those at high risk for lower respiratory infection, including the following: Emphysema Chronic cardiopulmonary disease Nursing home resident Diabetes mellitus Immunosuppressed Chronic renal failure Cystic fibrosis

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Hepatitis B      Health care workers in contact with blood  
Immunosuppressed  
Renal failure  
Dialysis  
Lifestyle risk populations:  
    Homosexual men  
    Bisexual men  
    IV drug use  
    Multiple sexual partners

Pneumococcal One      Immunosuppressed  
Renal failure  
Dialysis  
Diabetes mellitus  
Alcoholism  
Cirrhosis

*Well Adult Women Only*

<b>Age</b>	<b>Service</b>
18 Yrs. And older	Blood pressure check once every three years Blood cholesterol check once between ages 18 and 24 Blood cholesterol check every five years thereafter Gynecological exam—one per year to include the following: Gynecological exam Pap smear Breast exam One mammogram every year
50 Yrs. And older	One sigmoidoscopy every three years Osteoporosis evaluation Achilles heel ultrasound

*Well Adult Men Only*

<b>Age</b>	<b>Service</b>
18 Yrs. And older	Blood pressure check once every three years Blood cholesterol check once between ages 18 and 24 Blood cholesterol check every five years thereafter
40 Yrs. And older	Rectal prostate exam including PSA every other year
50 Yrs. And older	Sigmoidoscopy every three years

**Transplant Benefits**

The Plan provides benefits for expenses incurred in connection with liver, bone marrow, heart, pancreas, cornea, lung, and kidney Transplants including presurgery testing, medical expenses incurred by the donor and/or recipient directly as a result of the Transplant process, the cost of transporting the donated organ, and prescribed medications to inhibit

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rejection of the Transplant (“Transplant Benefits”). Transplants must be preauthorized in order for Transplant Benefits to apply. Covered services shall include only those services or supplies provided in connection with a cornea, heart, pancreas, lung, liver, kidney, or bone marrow Transplant that are within the scope of the Transplant Benefits, and shall expressly exclude all other services or supplies provided in connection with an organ Transplant. Non-covered Transplant services or supplies include, but are not limited to, the following:

- Any bone marrow Transplant in the treatment of disease or conditions resulting from infection from a human T-cell leukemia virus (e.g. AIDS).
- Any intestine Transplant.
- Any Transplant of a non-human organ or non-human bone marrow.
- Any bone marrow Transplant in the treatment of breast cancer, brain cancer, myeloma, or germ cell tumors.
- Any services or supplies in connection with the implantation of any artificial organ or device, regardless of whether implantation is a temporary measure while awaiting an available human organ.

Transplant Benefits are limited to a combined lifetime maximum of \$100,000.

### **Medical Supplies and Equipment**

The Plan provides benefits for the following:

- Medical supplies including, but not limited to, ileostomy supplies, I.V. therapy, oxygen, and surgical dressings. (The prescription drug card covers insulin syringes, lancets, test strips, and alcohol swabs.)
- Durable Medical Equipment. Rental of Durable Medical Equipment (not to exceed purchase price) when Medically Necessary for therapeutic use, unless the purchase of an item of Durable Medical Equipment will be less expensive than rental or if such equipment is not available for rental. In most cases, Educators will make payment on the standard model of Durable Medical Equipment. If additional items of comfort or convenience are desired, it will be the Member’s responsibility to pay for them. **For maximum benefits to be paid, Durable Medical Equipment costing more than \$300 must be preauthorized by submitting a written request, accompanied by a letter of medical necessity, to Educators, including a description of the Medical Necessity and the expected length of time that the equipment will be required.**
- Prostheses. Expenses in connection with a prosthesis will be covered no more than once every five years, except replacement will be covered if the replacement is Medically Necessary due to normal physical growth of the Covered Person.
- Orthotic devices of the feet, limited to a maximum of \$200 per person per year.
- Growth hormones. This benefit is limited to a maximum lifetime payment of \$8,000 per person.
- Pacemakers. Expenses in connection with a pacemaker will be covered no more than once every five years.

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- Dietary products used for the treatment of inborn errors of amino acid or urea cycle metabolism, when used under the direction of a physician.

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

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

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

Some eligible Mental Health and Drug/Alcohol Treatment services may be provided by a Dayspring/day treatment facility. These services require Preauthorization. Some services provided by Dayspring/day treatment facilities are not covered including but not limited to, convenience items, biofeedback, education, and family therapy. All limits and exclusions of the Plan apply.

Treatment or services related to mental health or emotional conditions including, but not limited to, a diagnosis of manic depression, manic depressive psychosis, or bipolar affective disorder, are included in the Mental Health and Drug/Alcohol Treatment. All exclusions of the Plan apply.

### **Other Limited Benefits**

The following benefits are limited and are available only if specific medical criteria are met. The portion a Member pays for these benefits *does not* apply toward the medical Coinsurance Maximum. The Plan provides limited benefits for the following:

- The following orthognathic procedures, including surgery, Hospital, and anesthesia, limited to a maximum lifetime payment of \$2,500 per person:
  - Sagittal split osteotomies to advance the mandible
  - Maxillary Lefor I osteotomies
  - Intraoral subcondylar osteotomies to set the mandible back
  - Segmental osteotomies
  - All other orthognathic surgery
- Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), limited to a maximum lifetime payment of \$500 per person.
- Total parenteral nutrition (TPN) for both Inpatient and outpatient treatment, limited to a maximum annual payment of \$10,000 per person.

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- New Medications. Educators will review all new medications within 90 days of FDA approval. Based on this review, new medications will be placed into one of the following categories. This includes any eligible medication prescribed by a physician or given in any setting.
    - **Significant Medication that may have life-saving or –extending potential (including, but not limited to, chemotherapy, transplant, and cardiac medications).** A Significant Medication will be covered immediately upon completion of Educators’ review and placement in the Significant Medication category, and the Covered Person will have a 50% Coinsurance. Twelve months after FDA approval, eligible Significant Medications will be covered as any other medication.
    - **New Therapeutic Class of Medication that treats an Illness, disease, condition, and/or symptom that was not treated with medication before the new medication was approved by the FDA, but that does not fall within the Significant Medication definition.** A medication that qualifies as a New Therapeutic Class of Medication will be covered six months after FDA approval, and the Covered Person will have a 50% Coinsurance. Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.
    - **A new medication that is in an existing therapeutic class or has similar indications or uses as a currently available FDA-approved medication.** Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.
  - Treatment of Primary Infertility, limited to a maximum annual payment of \$1,500 per person per year, and maximum lifetime payment of \$5,000 per person per lifetime.
  - A benefit for adoption in the amount of \$4,000, subject to any applicable Deductible, Copayment(s), and Coinsurance as are applied to any maternity benefit, shall be available to the Member when all of the following conditions are met:
    - The Member’s Plan provides maternity benefits for the Member or the Member’s Spouse and coverage is in effect on the date a newborn child is placed for the purpose of adoption.
    - A newborn child is placed for the purpose of adoption with the Member within 90 days after the child’s birth and the date of placement is on or after the Member’s effective date.
    - The Member submits a written request for the Indemnity Benefit for Adoption along with proof of placement of adoption. Proof of placement shall be a copy of the court order (or its equivalent) showing the date of placement for adoption. The written request must contain the child’s name, date of birth, and a statement regarding any other health coverage of the adoptive parent(s). The written request shall be addressed to the following address:

Educators Health Care  
852 East Arrowhead Lane  
Murray, UT 84107-5298
    - In the event of adoption of more than one newborn child (for example, twins), from the same birth, only one Benefit for Adoption applies.

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- In the event the Member and/or the Member's Spouse is covered for maternity benefit by more than one health benefit plan, the Benefit for Adoption shall be pro-rated between or among the plans so that the full amount provided by both or all of the plans does not exceed \$4,000.
  - In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety, the Member shall be liable for repayment of the Indemnity Benefit for Adoption. The full amount of such benefit shall be refunded by the Member to Educators within 30 days after that date the child is removed from placement.

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## PRESCRIPTION DRUG PROGRAM

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The prescription drug program, including the home delivery pharmacy service (mail-order) is separate from the medical plans outlined in this document. Coinsurance and Copayments for prescriptions do not apply toward the medical plan Deductible or Coinsurance Maximum.

### **Copayment and Coinsurance**

Copayments and Coinsurances are listed in the “Summary of Benefits” chart. The Participating Pharmacy entry indicates the amount the Members must pay if they purchase prescriptions at a participating pharmacy. The Non-participating Pharmacy entry indicates the amount the Members must pay if they purchase prescriptions at a non-participating pharmacy. The Mail Order entry indicates the amount the Members must pay if they purchase prescriptions through the home delivery pharmacy service. A list of Participating Pharmacies can be obtained by calling the prescription drug program customer service telephone number printed on the back of the Educators ID card.

### **Covered Drugs**

This program provides benefits for medications that require a prescription under state or federal law unless listed as excluded under the “Prescription Drug Exclusions” section. This program reviews prescribing, dispensing, and consumption patterns for potential abuse. The program may also involve the review of claims for drug interactions, drug conflicts, duplicate therapies, overutilization, and/or clinically appropriate maximum daily dose limits.

Members receive up to a 30-day supply per fill at retail pharmacies, and up to a 90-day supply per fill through the home delivery pharmacy service. A maximum of two vials of insulin per Copayment is allowed. When necessary, additional vials may be purchased during the month by paying an additional Copayment.

The following diabetic supplies are covered only if purchased at a participating pharmacy (see the *Participating Pharmacy* list): insulin syringes, lancets, test strips, and alcohol swabs.

### **New Medications**

Educators will review all new medications within 90 days of FDA approval. Based on this review, new medications will be placed into one of the following categories. This includes any eligible medication prescribed by a physician or given in any setting.

- **Significant Medication that may have life-saving or –extending potential (including, but not limited to, chemotherapy, transplant, and cardiac medications).** A Significant Medication will be covered immediately upon completion of Educators’ review and placement in the Significant Medication category, and the Covered Person will have a 50% Coinsurance. Twelve months after FDA approval, eligible Significant Medications will be covered as any other medication.
- **New Therapeutic Class of Medication that treats an Illness, disease, condition, and/or symptom that was not treated with medication before the new medication**

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**was approved by the FDA, but that does not fall within the Significant Medication definition.** A medication that qualifies as a New Therapeutic Class of Medication will be covered six months after FDA approval, and the Covered Person will have a 50% Coinsurance. Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.

- **A new medication that is in an existing therapeutic class or has similar indications or uses as a currently available FDA-approved medication.** Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.

### **Prescription Claims Review**

If Educators denies payment of a prescription claim which a Member believes is properly compensable under the applicable terms of the Plan, he or she may appeal by following the steps outlined in the “Claims Review Process” section.

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## PRESCRIPTION DRUG EXCLUSIONS

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### Pharmacy Items Excluded

The following items are excluded under the prescription drug and home delivery pharmacy service (mail order) programs, regardless of Medical Necessity or prescription by a licensed prescriber:

1. Medication received by a Member before coverage under the Plan is effective or after coverage under the Plan ends.
2. Medication that is not Medically Necessary.
3. Specialty drugs related to a Preexisting Condition for the period described in the *Preexisting Condition Limitation* section, except as described in the *Waiver of Preexisting Condition Exclusion* section, which can be found in the plan section of this policy.
4. Fertility medication (Primary or Secondary Infertility).
5. Anorexiant.
6. Chemotherapeutic medications, administered by IV or injections.
7. Hemophiliac medications.
8. Medication which is to be taken by, or administered to, an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
9. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
10. Any drug exceeding the number of days supply or doses eligible in the policy.
11. Charges for the administration of any drug.
12. Any drugs used for weight loss, smoking cessation, progesterone suppositories, and related services, or complications thereof.
13. Any drug that does not require a prescription except insulin.
14. Any over-the-counter drugs even if prescribed by a physician including, but not limited to, supplements and nutritional substitutes, enteral feedings, amino acids, electrolyte supplements, herbs, and related services.

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15. Any drug provided under another provision of the policy; e.g., Inpatient Hospital use.
  16. Any drug purchased for Cosmetic purposes, or complications thereof.
  17. Any item specifically limited or excluded in the medical exclusions. (See “Medical Plan Exclusions” section.)
  18. Any drug for erectile dysfunction.
  19. Any drug when it has been determined by the clinical consultants of Educators that there is over-utilization of drugs or evidence of drug abuse.
  20. Experimental drugs or any drug labeled “Caution, limited by Federal Law to Investigational Use” or dispensed by the government. Twelve months must have passed after FDA approval, before the Plan will consider coverage, unless Educators determines that the drug is a Significant Medication or a New Therapeutic Class of Medication. (See the *New Medications* section of the “Prescription Drug Program.”)
  21. Preventive medications including equipment and application of medications, including but not limited to, fluoride, vitamins, minerals, and homeopathic medicine. This exclusion does not include prenatal vitamins prescribed by a physician during pregnancy.
  22. Unit dose packaging of prescription drug products, including but not limited to, Factor VIII.
  23. Non-self-administered Injectables.

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## MEDICAL PLAN EXCLUSIONS

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

The Plan does not pay for the following:

1. Services received by a Member before coverage under the Plan became effective or after coverage under the Plan has terminated.
2. Services not specified as covered. There is no presumption of coverage.
3. Charges in excess of the Summary of Benefits, the Table of Allowances, or other Plan provisions.
4. Any Coinsurance, Copayment, or Deductibles incurred under this policy, until the Coinsurance Maximum has been reached.
5. Care, treatment, medication, supplies, or services rendered for any Preexisting Condition if treatment is rendered before the Member has been enrolled under this Plan for at least 10 months (or 18 months for Late Enrollees), unless reduced by the Waiver of Preexisting Condition Exclusion provision of this Plan.
6. Care, treatment, medication, supplies, or services rendered during the first eight months of coverage under this Plan, unless reduced by the Waiver of Preexisting Condition Exclusion provision of this Plan, for the following: tympanoplasty, tympanostomy, tonsillectomy, myringotomy, adenoidectomy, warts, moles, acne, lesions, mouth and external cysts, nasal septal repair, or elective sterilization.
7. Illness or injury caused by the negligent or wrongful act of another, or for which the Member is covered by any workers' compensation or similar law; except that Educators may advance benefits to or on behalf of the Member in such situations, subject to Educators' right of Subrogation and reimbursement set forth herein.
8. Illness or injury that a Member incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such Illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Member, except that Educators may elect to advance benefits to or on behalf of the Member in either situation, subject to Educators' right to Subrogation and reimbursement set forth herein.
9. Illness or injury for which the Member is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, except as otherwise provided herein, or as otherwise provided by law.
10. Except as otherwise provided by law, charges for Hospital Confinement, services, supplies, or treatment that the Member is not legally required to pay.

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11. Coverage for Illness or injury as a result of war or any act of war, whether declared or undeclared, or caused while performing service in the armed forces of any country.
  12. Charges for care, treatment, or surgical procedures which are not Medically Necessary.
  13. Care, treatment, or services provided when there are no symptoms of Illness or injury, or when there is or has been no diagnosis of Illness or injury.
  14. Care, treatment, or surgical procedures incurred primarily for convenience, contentment, or other non-therapeutic purposes.
  15. Expenses in connection with Adult immunizations, unless otherwise listed in this Plan.
  16. Osteoporosis screening services, except as listed on the *Evaluation Schedule Guidelines*.
  17. Expenses for personal hygiene, convenience, wellness, or preventive care (except as provided in the *Preventive Services* section of the Plan) including, but not limited to, buildings, motor vehicles, air conditioners, whirlpool baths, exercise equipment, or other multi-purpose equipment or facilities, related appurtenances, controls, accessories, or modifications thereof.
  18. Convenience items in or out of the Hospital such as guest trays, cots, telephone calls, and other services.
  19. Expenses for preparing medical reports, itemized bills, or claim forms.
  20. Expenses for shipping, handling, postage, sales tax, interest (except as allowed for late paid claims), finance charges, and other administrative charges.
  21. Transportation expenses including, but not limited to, mileage reimbursement, airfare, meals, accommodations, and car rental. This exclusion does not apply to the transportation of a donated organ for a covered organ Transplant.
  22. Ancillary charges made by a medical institution, Hospital, clinic, hospice, nursing home, or similar facility to hold or reserve a room during any temporary leave of absence of the Member, or in anticipation of a Hospital stay.
  23. Any care, treatment, or expenses for Cosmetic procedures or complications thereof, including Reconstructive or corrective procedures done primarily for Cosmetic purposes. A care, treatment, or procedure is considered Cosmetic when it is primarily intended to improve appearance or correct a deformity without restoring physical bodily function. Psychological factors such as, but not limited to, poor self-image or difficult peer or social relations are not relevant and do not justify a Cosmetic procedure as being Medically Necessary. The reversal of a non-covered Cosmetic procedure is not covered. This exclusion does not apply to

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Reconstructive Surgery performed as a result of a mastectomy, or treatment of physical complications at any stage of the mastectomy, including lymphedemas.

24. Care, treatment, services, or surgical procedures rendered for abdominoplasties, diastasis recti abdominous, protruding ears, breast enlargement, reduction mammoplasty or gynecomastia, or for complications thereof.
25. Care, treatment, services, or surgical procedures rendered for lower lid blepharoplasty.
26. Health services and associated expenses for the surgical treatment and non-surgical medical treatment of obesity (whether morbid obesity or not) including, but not limited to, weight loss programs, or for complications thereof.
27. Expenses in connection with gastric banding, gastric stapling, or digestive bypass, or for complications thereof.
28. Educational or behavioral modification services or counseling including, but not limited to, biofeedback, weight control clinics, stop-smoking clinics, cholesterol counseling, exercise programs, or other types of physical fitness training. This exclusion does not apply to training for the care of diabetes.
29. Confinement, education, or training in a nursing home, rest home, or similar establishment, including an institution that is primarily a school or other institution for training, except an Extended Care Facility as provided in this Plan.
30. Expenses in connection with Custodial Care.
31. Charges in connection with institutional care, including residential treatment or programs, which as determined by the Plan, is for the primary purpose of controlling or changing the environment for the individual.
32. Charges for cognitive therapy.
33. Care or treatment of learning disability, mental retardation, or chronic organic brain syndrome, except services required to diagnose any of the above.
34. Treatment or services for marriage counseling and any counseling or psychotherapy for relief of family or marital discord, divorce, preparation for marriage, encounter groups, parental counseling, treatment for situational disturbances such as financial or environmental problems, or other types of everyday stresses and strains.
35. Expenses for treatment of personality disorders, behavior disorders, or chronic situational reactions; phobias, occupational, religious, or other social maladjustment; or non-specific conditions such as acts of impulse including, but not limited to, gambling, pyromania, and kleptomania.
36. Care, treatment, procedures, or services for transsexualism, gender dysphoria, sexual reassignment, psychosexual identity disorder, or psychosexual dysfunction.

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This exclusion does not apply to the initial assessment and diagnosis of the condition.

37. Any loss caused or contributed to by the Member committing, or attempting to commit, an Act of Aggression, or an illegal act. This exclusion does not apply to benefits for victims of domestic violence or for Members with mental health conditions.
38. Care, treatment, or services for any Illness or injury resulting from, or caused by, intoxication, at or above the legal limit, or the use of any drug unless such drug is administered or prescribed by a physician and taken in the manner prescribed. This exclusion does not apply if such Illness or injury results from a medical condition.
39. Care, treatment, or services, including Custodial Care, for substance abuse or the aftereffects of substance abuse including, but not limited to, alcoholism, narcotism, or use of hallucinogenic drugs or similar substances, except as specifically provided under Mental Health and Drug/Alcohol treatment.
40. Infertility services including, but not limited to, the following:
  - Artificial insemination, sperm washing, sperm banking, and/or storage.
  - Donor costs.
  - Experimental or Investigative treatment.
  - Gamete intrafallopian transfer (“GIFT”).
  - Hamster egg penetration tests.
  - In-vitro fertilization (IVF).
  - Medications for Infertility and ultrasounds associated with Infertility medications therapy.
  - Non-participating Provider or facility services for Infertility.
  - Zygote intrafallopian transfer (“ZIFT”).
  - Surrogate mothers.
  - Secondary Infertility.
  - Expenses in connection with retrieval or collection of semen and/or ovum.
41. The adoption benefit (see *Other Limited Benefits* section) in connection with the adoption of any child over 90 days of age.
42. Expenses for insertion or removal of contraceptive devices or medications, or complications thereof.
43. Non-oral forms of contraceptives including, but not limited to, Intra Uterine Devices, (IUDs), Depo Provera, injections, Norplant, Ortho Evra (patch), and Nuvo Ring.
44. The reversal of a surgically performed sterilization, subsequent sterilization, or ovulation-inducing drugs or injections.
45. Expenses in connection with abortion, except as follows:

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- Where documented by medical evidence that the life of the mother would be endangered if the fetus were carried to term.
  - Where the pregnancy is the result of incest or rape.
46. Care, treatment, or surgical procedures for erectile dysfunction.
  47. Care, treatment, or devices to aid in female sexual arousal disorder including, but not limited to, Eros Clitoral Therapy Device.
  48. Expenses in connection with a penile prosthesis.
  49. All organ Transplant services when rendered by Non-participating Providers.
  50. Services for cross matching and/or harvesting organs from live or deceased donors for all non-covered Transplant/Implant services and whenever the organ recipient is not a Member.
  51. Repair or replacement of any otherwise covered Implant when rendered by Non-participating Providers.
  52. Any bone marrow Transplant in the treatment or care of any disease or condition resulting from infection from a human T-cell leukemia virus or HIV and central nervous system metastases or myeloma.
  53. Expenses for and in connection with implantable electrical, pneumatic, mechanical, or semi-mechanical devices or prostheses including, but not limited to, neurostimulators of any kind and for any purpose, artificial hearts, LVAD, LVAS, ventricular-assist devices, and deep brain stimulators (DBS). This exclusion does not apply to heart pacemakers.
  54. Duplication, replacement, upgrade, improvement, alteration, or repair of existing Durable Medical Equipment, except that this exclusion does not apply to the replacement of Durable Medical Equipment other than Durable Medical Equipment that Educators has previously paid for under *Medical Supplies and Equipment*. This exclusion includes parts, such as but not limited to, batteries. Replacement of existing Durable Medical Equipment will only be covered if the replacement is Medically Necessary due to normal physical growth of the Member. Expenses related to modifications and/or improvements to home, van, or other vehicle, regardless of Medical Necessity are excluded. This exclusion does not apply to medical supplies for use with insulin pumps and/or insulin infusion pumps.
  55. Care, treatment, or surgical procedures in connection with hearing aids or the fitting of hearing aids or appliances including, but not limited to, cochlear implantation.
  56. Eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses, with the exception of one lens per operated eye following eye surgery; for example, an external contact lens or surgically implanted intraocular lens.

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

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before Educators will consider coverage, unless Educators determines that a drug is a Significant Medication or a New Therapeutic Class of Medication. (See the *New Medication* section of the “Prescription Drug Program.”)

65. Care, treatment, or services including, but not limited to, testing associated with autogenous urine immunization, sublingual provocation, leukocytotoxicity, and subcutaneous provocation and neutralizing.
66. Expenses in connection with herbal, holistic, or homeopathic treatment, or for complications thereof.
67. Genetic counseling and testing except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.
68. Expenses related to a sleep laboratory or facility, except services related to sleep apnea, unless otherwise indicated. This includes, but is not limited to, insomnia.
69. Expenses for any of the following:
  - Ambulance services when the individual could be safely transported by means other than ambulance.
  - Air ambulance services when the Member could be safely transported by ground ambulance or by means other than ambulance.
  - Ambulance services beyond transportation to the nearest facility expected to have appropriate services for the treatment of the injury or Illness involved.
  - Ambulance services for conditions, other than injuries received in an Accident, not deemed Life-threatening.
70. Special duty nursing services including the following:
  - That ordinarily would be provided by the Hospital staff or its Intensive Care unit. (The Hospital benefit pays for general nursing service by Hospital staff.)
  - Requested by, or for the convenience of, the Member or the Member’s family or consisting primarily of bathing, feeding, exercising, house keeping, moving the Member, giving medication, or acting as a companion or sitter, or when otherwise deemed not to be Medically Necessary.
  - Rendered by a private duty nurse, who is an immediate family member (e.g. Spouse, parent, or who lives in the home of the Member).
  - Home Health aides or services
71. Charges for physician calls in excess of one per physician per day
72. Expenses for appointments scheduled but not kept
73. Expenses for telephone consultations.
74. Care, treatment, or services rendered by any Provider who is an immediate family member (e.g. Spouse, parent).

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75. A physician assistant, when billed for assisting with surgery, as part of, or in addition to, the attending surgeon's bill.
76. Except as otherwise provided in the Plan, services performed by a Provider that is not covered by the Plan including, but not limited to, the following:
- Acupuncturist
  - Registered dietician, unless in connection with the treatment of diabetes
  - Doctor of education
  - Clergy
  - Family nurse practitioner who is not a Participating Provider
  - Home Health aid
  - Nurse's aid
  - Hygienist
  - Hypnotist
  - Medical assistant
  - Massage therapist
  - Naturopath
  - Physician's assistant/doctor's assistant
  - Practical nurse/vocational nurse
  - Personal fitness trainer/coach
77. All self-administered Injectables. (Refer to "Prescription Drug Program.") This exclusion does not apply to the following:
- Neupogen (Filgrastim)
  - Epogen, Procrit (Epoetin Alfa)
  - Lupron, Lupron Depot, Lupron Depot-3 month, Lupron Depot-4 month, Lupron Depot-Ped, Lupron Depot-Gyn, Oaklide (Leuprolide Acetate)
  - Neulasta (Pegfilgrastim)
  - Neumega (Oprelvekin)
  - Leukine, Prokine (Saragramostim)
78. All medications that are excluded under the "Prescription Drug Program" are also excluded under Medical. This exclusion does not apply to the following (under Medical plan):
- Chemotherapeutic medications.
  - Hemophiliac medications.
  - Otherwise covered medication which is to be taken by, or administered to, an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
  - Any otherwise covered drug provided under another provision of the policy; e.g. Inpatient Hospital use.

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- Unit dose packaging of prescription drug products, including but not limited to, Factor VIII.
  - Medically Necessary enteral feeding when administered via nasogastric, gastrostomy, or jejunostomy tube.
79. All services, equipment, and supplies provided or ordered to treat complications of a non-covered illness, injury, condition, situation, procedure, or treatment.

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## CONTINUATION OF COVERAGE

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### COBRA Continuation of Coverage Requirements

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

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

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

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

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

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Subsequent premiums must be paid by the first of each month. Failure to pay this premium within 31 days of the premium due date for any month will result in cancellation of all coverage(s), *without notice*. Any claims received for services rendered during the 31-day Grace Period will be held for processing until premium payment is received.

- **Period of Continuation Coverage.** If elected, the maximum period for continued coverage for a “qualifying event” involving termination of employment or reduced working hours is 18 months. For all other “qualifying events,” the maximum period is 36 months. Other events will cause coverage to end sooner and this will occur on the earliest of any of the following:
  - The date WSU ceases to provide any group health plan to any Employee;
  - The date the Member fails to make any required premium payment; or
  - The date the Member becomes either of the following:
    - A covered Employee under any other group health plan that does not contain any exclusion or limitation with respect to any Preexisting Condition the Member has; or
    - Entitled to Medicare.
  
- **Extension of Coverage for Disabled Individuals.** If a Member is disabled according to Social Security any time within the first 60 days of COBRA coverage (or a qualifying new child is so disabled within 60 days of the birth, adoption, or placement for adoption), the Member may extend the 18 months COBRA coverage period to 29 months from the termination date or reduction in hours date. This extension may apply independently to each qualified Member regardless of whether the disabled individual is covered under a COBRA election.

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

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

COBRA coverage will end the earliest of the following:

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

### **Waiver of Premium**

If a Subscriber becomes disabled while covered under this Plan, and would otherwise lose coverage, he or she may apply for either COBRA continuation coverage or for continuation of medical coverage for the Subscriber and eligible Dependents under WSU’s base plan without payment of the Employee portion of the premium (Waiver of Premium). The

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waiver of premium benefit will begin after a continuous six month waiting period has elapsed.

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

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

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

If the Subscriber ceases to be Totally Disabled and is then eligible for coverage under the provisions of this Plan, the coverage will be continued only if the premium payments are resumed.

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

Waiver of premium benefits may continue for a maximum of 24 months, or until age 65, whichever comes first.

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

- For covered Dependents, other than the Subscriber's Spouse, the individual ceases to be an eligible Dependent when either of the following occurs:
  - a. The date the Dependent is married; or
  - b. The last day of the calendar month coinciding with the Dependent's 26<sup>th</sup> birthday.
- For covered Spouse, the date the divorce from the Subscriber is final;
- For the Subscriber and covered Dependents, the effective date of any election by the Subscriber to cease coverage for the Subscriber and/or his or her Dependents;
- For the Subscriber and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;

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

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## COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

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

Any COB Plan that does not contain a coordination of benefits provision will be considered primary.

If a person is covered by two COB Plans that both have a coordination of benefits provision, the order of payment will be as follows:

- A COB Plan that covers a person as an employee (including early retirees, if applicable) will be primary over a COB Plan that covers the same person as a Dependent, retiree, or laid-off individual.
- A COB Plan covering a person as a Dependent child of parents who are married or living together will be primary according to which parent has the earlier birthday (month and day) in the year. If both parents have the same birthday, the COB Plan covering the parent for the longer period of time will be primary.
- If the other COB Plan does not have the 'birthday' rule, but instead has a rule based upon another order, and if, as a result, the coordinating plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- If two or more COB Plans cover a person as a Dependent child of parents who are divorced, separated, or not living together, benefits for the child are determined in this order:
  1. The COB Plan of the parent with custody of the child.
  2. The COB Plan of the Spouse of the parent with custody of the child.
  3. The COB Plan of the parent not having custody of the child.
  4. The COB Plan of the Spouse of the parent not having custody of the child.

If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health insurance coverage of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that COB Plan are determined first. If the parent with responsibility has no coverage for the child's health care services, but that parent's Spouse does, the Spouse's COB Plan is primary. The COB Plan of the other parent shall be the secondary COB Plan. This paragraph does not apply with respect to any claim determination period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of the court decree state that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses or health coverage of the child, and the child's residency is split between the parents, the order of benefit determination rules outlined above for non-divorced or non-separated parents

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will apply. This paragraph does not apply with respect to any claim determination period or Plan Year during which benefits are paid or provided before the entity has that actual knowledge.

- If there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the COB Plans of the parents and the parents' Spouses, if any, is the following:
  1. The COB Plan of the parent with custody.
  2. The COB Plan of the Spouse of the parent with custody.
  3. The COB Plan of the parent not having custody.
  4. The COB Plan of the Spouse of the parent not having custody.
- If the preceding rules do not establish an order of benefit determination, the benefits of a COB Plan that has covered the person for the longer period of time will be primary over a COB Plan that has covered the person for a shorter period of time.

To determine the length of time a person has been covered under a COB Plan, two COB Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

The start of a new COB Plan does not include any of the following:

- A change in the amount or scope of a COB Plan's benefits.
- A change in the entity which pays, provides, or administers the COB Plan's benefits.
- A change from one type of COB Plan to another, such as from a single employer COB Plan to that of a multiple plan.

The claimant's length of time covered under a COB Plan is measured from the claimant's first date of coverage under that COB Plan. If that date is not readily available, the date the claimant first became a Subscriber or member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present COB Plan has been in force.

When the Plan is primary, the benefits of another COB Plan will not be considered for the purpose of determining the benefits under this Plan.

The primary COB Plan must pay or provide its benefits as if the secondary COB Plan or plans did not exist. A primary COB Plan may not deny payment on the grounds that a claim was not timely submitted if the claim was timely submitted to one or more secondary COB Plans and was submitted to the primary COB Plan within 36 months of the date of service. 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.

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

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- If this Plan is the primary plan, Educators will pay or provide its benefits on a primary basis.
  - If this Plan is the secondary plan, Educators 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 Educators' liability; and if the other COB Plan does not provide the information needed by Educators to determine its benefits within a reasonable time after it is requested to do so, Educators will assume that the benefits of the other plan are identical to this Plan, and will pay its benefits accordingly. However, Educators will adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the other COB Plan.
  - If the other COB Plan reduces its benefits so that the Member receives less in benefits than he or she would have received had Educators paid or provided its benefits as the secondary COB Plan and the other COB Plan paid or provided its benefits as the primary COB Plan, and governing state law allows the right of Subrogation, then Educators shall advance to or on behalf of the Member an amount equal to such difference.
    - In no event will Educators 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, Educators shall be subrogated to all rights of the Member against the other plan.

If by applying the rules of Order of Benefit Determination, the Plan is determined to be secondary, the benefits may be reduced as follows:

- When one of the COB Plans has contracted for discounted Provider fees, the secondary COB Plan may limit payment to any Copayments and Deductibles owed the Member after payment has been made by the primary COB Plan.
- If none of the COB Plans have contracted for discounted Provider fees, the secondary COB Plan may reduce its benefits so that the total benefits paid or provided by all COB Plans for a covered service are not more than the highest Allowable Expense of any of the plans for that service. When Educators is determined to be a secondary COB Plan, Educators will calculate the amount of benefits it would normally pay in absence of coordination, including the application of credits to any policy maximum and apply the payable amount to unpaid covered charges owed by the Member after benefits have been paid by the primary COB Plan. This amount will include Deductibles, Coinsurance, and Copayments left owing by the Member. Educators will use its own Deductibles, Coinsurance, and Copayments to calculate the amount it would have paid in the absence of coordination. This calculation will be based on the total Allowable Expenses rather than the amount left owing after payment by any primary COB Plans. Educators will not pay a higher amount than what it would have paid in the absence of coordination. As a secondary COB Plan, Educators will not make payment for any service that is not a benefit of its plan.

Whenever payments that should have been made under this Plan have been made under any other COB Plan, Educators 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

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regarded as benefit payment, and Educators will be fully discharged from liability under this Plan to the extent of the payment.

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

- Any person to, or for whom, such payments were made:
  - The Member, 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 material misrepresentation by the Member.
  - The Provider, limited to a time period of 36 months from the date a payment is made unless the reversal is due to fraudulent acts or statements or material misrepresentation by the Member.
- Any other insurance companies.
- Any other organization.

If attempts to recover such overpayments are exhausted, the Member is ultimately responsible for reimbursement to Educators, subject to the time limits referenced above. In order to avoid overpayments, it is important for the Member to take responsibility in reporting to Educators any changes in the status of other insurance coverage.

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

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

The amount of medical benefits paid by group, group-type, and individual automobile “no-fault” medical payment contracts are not payable under this Plan. However, when all available no-fault auto medical insurance benefits have been paid, this Plan will pay according to its normal schedule of benefits. If the Member does not have proper no-fault insurance and is involved in an Accident, no benefits will be paid under this Plan until the minimum no-fault auto medical benefits have been paid by the Member, 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 this Plan will be required to give WSU and Educators any facts needed to pay a claim.

### **Internal Coordination of Benefits**

When a husband and wife are both eligible for group medical insurance by Educators as Employees of the same or different policyholders, the person whose birthday comes first in the year must enroll in the medical program for self, Spouse, and eligible Dependents; the other may enroll for self only, but include Spouse and all eligible Dependents on the enrollment form. Under this arrangement, full coordination of benefits, not to exceed the Table of Allowances, will be extended to all eligible members of the family according to the definitions of this policy.

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

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## CLAIMS PROCEDURE

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

### **How to File a Claim**

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

EDUCATORS HEALTH CARE INC.  
C/O Educators Mutual Insurance Association of Utah  
852 East Arrowhead Lane  
Murray, Utah 84107-5298

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

### **Requests for Additional Information**

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

- To obtain details of an Accident.
- To determine if a condition is preexisting.
- To expedite coordination of benefits.
- To conduct an audit.

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

### **Exhaustion of Administrative Remedies**

No action at law or in equity may be brought against WSU, or Educators, and no arbitration request may be made, until the Member has exhausted the Claims Review Process, as provided in this Plan.

### **Appointment of Authorized Representative**

The Member may appoint an authorized representative to act on his or her behalf in pursuing a benefit claim or appealing an adverse benefit determination. The Member shall appoint the authorized representative by signing an "Appointment of Authorized Representative" form available from Educators, with the authorized representative

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accepting such appointment by signing the Appointment of Authorized Representative form; provided, however, that, in the case of a claim involving an Urgent Preauthorization Request as defined in this Plan, a health care Provider, with knowledge of the Member's medical condition shall be permitted to act as the authorized representative of the Member. The Member desiring to appoint an authorized representative shall submit the fully executed form to Educators.

### **Claims Review Process**

If Educators denies payment of a Post-service Health or prescription claim which a Member believes is properly compensable under the applicable terms of the Plan, the Member shall within the time limits provided in subparagraphs one through five below after receipt of notice of denial of payment or coverage take the matter up with **Educators' Claims Review Committee**, which shall be comprised of at least three employees of Educators who did not participate and are not supervised by any person who participated in the initial decision. If agreement is not reached on the claim, the Member shall within the time limits provided in subparagraphs one through five below after the decision of the Claims Review Committee have the right to request a second level appeal regarding the disputed claim and an in-person hearing by **Educators Board of Directors**, which shall include at least one consumer representative. This request must be in writing and must be received by Educators, within the time limits provided in subparagraphs one through five below after receipt of notice indicating the decision of the Claims Review Committee. The Educators Board of Directors' notice of decision will inform the Member of its decision and, if adverse to the Member, the basis of its decision in writing. If the Member disagrees with the decision of the Educators Board of Directors in the second level appeal, and it is a case regarding the determination of Medical Necessity, the Member may request an Independent Review of Medical Necessity. If it deals with any other matter, the Member shall have **a right to submit the matter to binding arbitration or to pursue any remedies available at law or equity**. If the Member elects binding arbitration, then all relevant information and the positions of all parties shall be submitted to the arbitrator, who shall then review the matter and make a decision which is final and binding on Educators and the Member. In no event shall the arbitrator have the power to extend or expand upon the provisions of the Plan. The procedure for arbitration shall be as provided in the *Arbitration* provision of this Plan.

The following time limits shall apply to Post-service Health Claims:

- (1) Educators will provide a notice of its initial claim decision within (a) 30 days after receiving the initial claim, or (b) 45 days after receiving the claim if Educators determines that an extension is necessary due to matters beyond its control and if Educators provides an extension notice during the initial 30-day period. If the extension is due to the Member's failure to submit sufficient information necessary to decide a claim, the extension notice shall specify the additional required information and the Member will have at least 45 days to provide the additional information. The period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent until the date on which the Member provides the additional required information.
- (2) If Educators denies the claim in whole or in part, the Member has 180 days after receiving notice of the claim denial to appeal the decision in writing.

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(3) The Claims Review Committee will provide notice of its decision on appeal within 30 days after receiving the request for appeal.

(4) If the Claims Review Committee denies the claim in whole or in part on appeal, the Member has 180 days after receiving notice of the denial to request a second level appeal in writing.

(5) The Board of Directors will provide notice of its decision on the second level of appeal within 30 days after receiving the notice of appeal to the Board.

### **INDEPENDENT REVIEW OF MEDICAL NECESSITY**

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

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

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

The Member may initiate such independent review of Medical Necessity by giving written notice to Educators of the Member's election to proceed with independent review within 180 days from the date of the receipt, in writing, from Educators of the final adverse benefit determination of Medical Necessity from the Claims Review Process. A failure by the Member to timely give such written notice within 180 days after the receipt, in writing, of the final adverse benefit determination of Medical Necessity from the Claims Review Process shall be deemed to be an acceptance by the Member of the said final adverse benefit determination of Medical Necessity and that the Member accepts the same as a final and binding adjudication.

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

### **ARBITRATION**

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

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The Member may initiate arbitration proceedings by giving written notice to Educators of the election to proceed with binding arbitration. A failure to give such notice or to pursue any remedies available at law or equity, for more than 180 days after the delivery in writing of the final adjudication from the Claims Review Process shall be deemed to be an acceptance of the said final adjudication as a final and binding adjudication.

The procedures and rules governing the requested arbitration proceeding shall be (1) the terms of this Plan governing arbitration and the procedures for the same and (2) the Utah Arbitration Act (Utah Code Ann. 78-31a-1 et seq). In the event of any inconsistency between the listed procedures and rules, the earlier listed provisions shall govern over the later listed provisions.

The arbitration shall be conducted by a single arbitrator selected by mutual agreement of the Member and Educators from a panel provided by an independent arbitration association. In the absence of an agreement by the parties as to the selection of an arbitrator, the arbitrator named by each of the parties shall, together, select the arbitrator for the proceeding from the said panel. Educators will bear the cost of arbitration, filing fees, administrative fees, and arbitrator fees. Other expenses of arbitration including, but not limited to, attorney's fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses will be borne by the party incurring those expenses.

The parties agree that the award may not include attorneys' fees incurred, regardless of the fact of whether that party prevails in the arbitration proceeding. In other words, the Member and Educators are each responsible for any attorneys' fees incurred by either of them in connection with the claim, controversy, or dispute, whether before, during, or after the arbitration proceeding, except that a court may award reasonable costs of a motion to confirm, vacate without directing a rehearing, modify, or correct an award, as provided in Utah Code Ann. § 78-31a-126(1) and (2). The decision and award of the arbitration shall be final and binding upon the parties.

### **Subrogation and Reimbursement**

When Educators has advanced payment of benefits to or on behalf of a Member for any bodily injury actionable at law or for which the Member may obtain a recovery from a third party, Educators acquires both a right of Subrogation against the third party and a right of reimbursement against the Member. In such situations, the Member has the following obligations:

- The Member must reimburse Educators, up to the amount of such benefits advanced or paid by Educators, out of any recovery obtained by the Member from the third party (or such party's liability insurance) by judgment, settlement, or otherwise, whether or not the Member is or has been made whole. Educators is entitled to the first dollar of any recovery by the Member and each dollar thereafter up to the amount of benefits advanced or paid by Educators for the injuries to the Member that were caused by the third party.
- The Member cannot limit or avoid such reimbursement obligation to Educators by any agreement with the third party or any assignment or designation of such proceeds.

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- The Member must not release or discharge any claims that the Member may have against any potentially responsible parties without written permission from Educators.
  - The Member must fully cooperate with Educators (including, but not limited to, executing all required instruments and papers), if Educators chooses to pursue its own right of Subrogation against the third party; Educators' right of Subrogation is limited to the amount of benefits advanced or paid by Educators to or on behalf of the Member as a result of the fault of the third party, and Educators' right to recover such benefits from the third party does not depend upon whether the Member is made whole by any recovery.

# Weber State University

**Administered by Educators Mutual Insurance Association of Utah**

*Administration..... 262-7476 • 1-800-662-5850*

*Customer Service..... 262-7475 • 1-800-662-5851*

PLEASE NOTE: All services are subject to Educators Table of Allowances. When using non-participating Providers, the Covered Person is responsible for all fees in excess of the Table of Allowances.

<b>Weber State University Summary of Benefits July 1, 2005 - June 30, 2006</b>	<b>EDUCATORS TRADITIONAL DENTAL BENEFIT</b>
<b>PRELIMINARY INFORMATION</b>	
Basic and Major Services Failure to enroll at first opportunity results in 2 year exclusion of prosthodontic and orthodontic services, as well as crown build-ups and crowns. A waiting period of five years from the effective date of continuous coverage applies to replacement of teeth that are missing prior to the effective date of coverage.	
Annual Maximum (Per Person)	\$1,500
Annual Deductible (Per Person/Family)	None
Dependent Age Limit	26
<b>DIAGNOSTIC</b>	<b>YOU PAY</b>
Exam (2 per year)	20%
X-ray – Bitewing (2 per year)	20%
Full Mouth X-ray - panorex (1 per 3 year period)	20%
Periapical X-ray	20%
<b>PREVENTIVE</b>	<b>YOU PAY</b>
Prophylaxis (2 per year)	20%
Fluoride (2 per year)	20%
Prophylaxis – Fluoride (2 per year)	20%
Emergency Treatment	20%
Sealants (Dependent children only) (\$6 per tooth)	50%
<b>RESTORATIVE</b>	<b>YOU PAY</b>
Space Maintainers (Dependent children to the 17 <sup>th</sup> birthday)	20%
Amalgam Filling (same surface every 18 months)	20%
Resin/ Composite Filling (same surface every 18 months)	20%
Pin	20%
Stainless Steel Crown (child treatment)	20%
Post	20%
Post/Crown Build Up	20%
Crown (1 per tooth per 5 year period)	50%
Crown Build Up	20%
Tissue Conditioning	20%
Recement Bridge	20%
Recement Crown	20%
<b>ENDODONTICS</b>	<b>YOU PAY</b>
Pulp CAP (1 per tooth)	20%
Pulpotomy (1 per tooth)	20%
Root Canal	20%
Apicoectomy	20%
<b>PERIODONTICS</b>	<b>YOU PAY</b>
Periodontal Service by Periodontist (1 per 6 month period)	20%
Periodontal Prophylaxis (1 per 6 month period)	20%

<b>Weber State University Summary of Benefits July 1, 2005 - June 30, 2006</b>	<b>EDUCATORS TRADITIONAL DENTAL BENEFIT</b>
Periodontal - Scale Full Mouth (1 per 6 month period)	20%
<b>PROSTHODONTICS REMOVABLE</b>	<b>YOU PAY</b>
Dentures – Upper (1 per 5 year period)	50%
Partials – Upper (1 per 5 year period)	50%
Dentures – Lower (1 per 5 year period)	50%
Partials – Lower (1 per 5 year period)	50%
Denture Repair	50%
Denture Reline - Office reline not a benefit (1 per 3 year period)	50%
<b>PROSTHODONTICS, FIXED</b>	<b>YOU PAY</b>
Onlay (Gold) Metallic (1 per tooth per 5 year period)	50%
Inlay	Not Covered
Pontic (1 per 5 year period)	50%
Implants – Limited to \$225.00 ( 1 per tooth, per 5 year period)	50%
Abutment (1 per 5 year period)	50%
<b>ORAL SURGERY</b>	<b>YOU PAY</b>
Extraction	20%
Surgical Extraction of Erupted Teeth Only	20%
Surgical Extraction of Impacted Teeth	20%
Oral Surgery - Frenectomy, Alveolectomy, Crown Exposure Removal of Palatal and Mandibular Tori,	20%
<b>ANESTHESIA</b>	<b>YOU PAY</b>
Anesthesia	20%
<b>ORTHODONTICS</b>	<b>YOU PAY</b>
Dependent Orthodontics (\$1,000 per lifetime)	50%
Adult Orthodontics (\$1,000 per lifetime)	50%

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## EDUCATORS TRADITIONAL DENTAL PLAN

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### Diagnostic/Preventive Benefits

- Oral examinations two times per Contract Year.
- X-rays are covered as follows:
  - Full mouth – once every three years
  - Supplementary bitewings – two times per Contract Year
  - Supplementary periapical – as needed
- Cleaning and scaling teeth (prophylaxis) two times per Contract Year.
- Application of fluoride in conjunction with cleaning two times per Contract Year.
- Sealants for children up to the 26<sup>th</sup> birthday.

### Basic Benefits

- Space maintainers used to maintain the present position of a tooth following an extraction, for children up to the 17<sup>th</sup> birthday.
- Extractions and other oral surgery involving procedures for simple and complicated extractions of erupted and impacted teeth, including frenectomy, alveolectomy, removal of palatal and mandibular tori, and crown exposure. Post-operative care and removal of sutures are considered part of the surgical procedure and are covered only when included in the charge for the entire surgical procedure.
- Treatment of gum and mouth tissue disease (periodontic services), including post-operative care within six months of treatment.
- Endodontic treatment, including root canal therapy. One pulp cap per tooth is allowed. Bases are not covered.
- Restoration of decayed teeth with amalgam, synthetics, or plastic, up to one restoration per surface. Repairs to restorations are allowed only once every 18 months, regardless of the reason. Tooth preparation, temporary restorations, cement bases, impressions, and local anesthesia are all considered part of the restoration and are covered only when included in the charge for the entire process.

### Major Benefits

- Gold onlays and crowns are covered if teeth cannot be restored with amalgam, synthetic porcelain, or plastic. Benefits are payable once every five years for the same tooth.
- Initial installation of a removable or fixed partial or complete denture once every five years. Fixed bridges for patients under age 16 are covered up to the amount allowed for a removable partial denture.
- One laboratory relines is covered following the initial installation of a denture and once every three years thereafter. Office relines are not a covered benefit.
- Implants in lieu of crowns and bridges, limited to \$225. All services and products related to the implant (including, but not limited to, the anchor, the post, and the artificial tooth) apply toward the implant limit.
- Replacement of missing teeth with complete or partial dentures, fixed bridges, or implants is covered. Services to replace teeth that are missing prior to the effective date of coverage are not eligible for a period of five years from effective date of continuous coverage with Educators. However, Educators may review the abutment teeth for eligibility of prosthetic benefits on their own merit.

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- Replacement of a denture or implant that is no longer serviceable is covered once every five years.

### **Orthodontic Benefits**

Orthodontic services are covered for functionally related problems, not for Cosmetic purposes, for eligible unmarried Dependent children up to the 26<sup>th</sup> birthday, the eligible Employee, and Spouse.

- Initial diagnostic records (study models, facial photographs, etc.) are covered only if eligible orthodontic treatment is rendered.
- Orthodontic treatment, including diagnostic procedures, X-rays, and appliance therapy.
- Charges for a case in progress, which is defined as the placement of bands, will not be allowed if placement occurs prior to the effective date of this policy.

### **Enrollment**

Failure to enroll in the dental plan at first opportunity results in a two-year exclusion of prosthodontic and orthodontic services.

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## TRADITIONAL DENTAL PLAN EXCLUSIONS

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

Educators Traditional Dental Plan does not pay for the following:

1. Expenses for preparing dental reports, itemized bills, or claim forms.
2. Illness or injury caused by the negligent or wrongful act of another, or for which the Covered Person is covered by any workers' compensation or similar law; except that Educators may advance benefits to or on behalf of the Covered Person in such situations, subject to Educators' right of Subrogation and reimbursement set forth herein.
3. Illness or injury that a Covered Person incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Covered Person, except that Educators may elect to advance benefits to or on behalf of the Covered Person in either situation, subject to Educators' rights of Subrogation and reimbursement set forth herein.
4. Illness or injury for which the Covered Person is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, except as otherwise provided herein, or as otherwise provided by law.
5. Services that are provided by any federal or state government agency or are provided without cost by any municipality, county, or other political subdivision or community agency.
6. Charges for services related to birth defects or Cosmetic Surgery or dentistry for solely Cosmetic reasons including, but not limited to, bonding and veneers.
7. Any procedure started prior to the date the patient became covered for such services under this policy.
8. Medical care, confinement, treatment, services, use of facilities, or supplies for which charges are made by a facility, including freestanding nursing home, rest home, or similar establishment.
9. Plaque control programs, oral hygiene instruction, and dietary instruction.
10. Myofunctional therapy.
11. Lab costs for an oral tissue biopsy.

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12. Treatment to correct problems with the way teeth meet or to adjust bite (alter vertical dimensions or restore or equilibrate occlusion) except as covered under orthodontia.
  13. Care, treatment, operations, supplies, appliances, aids, devices, or drugs that are not FDA approved.
  14. Any loss caused, or contributed to, by the Covered Person committing or attempting to commit an act of aggression or an illegal act.
  15. Care, treatment, operations or supplies that are illegal, Experimental, Investigational, or for research purposes by the United States medical profession, that are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted dental/medical practices.
  16. Expenses in connection with transportation or mileage reimbursement.
  17. Expenses including, but not limited to, air fare, meals, accommodations, and car rental.
  18. Medications labeled “Caution, Limited by Federal Law to Investigational Use” or experimental drugs. Twelve months must have passed after FDA approval before the Plan will consider coverage.
  19. Services that are not Medically Necessary or Cosmetic services including veneers, special techniques, precious metals used for removable appliances other than orthodontics, precision attachments for partial dentures or bridges, and personal characterization.
  20. Any procedure or appliance to correct or treat temporomandibular joint dysfunction (TMJ).
  21. Transplants, or reimplantations, Cosmetic implants, or associated appliances or services rendered in conjunction with Cosmetic implants, for example, crowns or bridges.
  22. Hospital services.
  23. Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.
  24. Temporary restorations, appliances, or procedures of any nature, except that temporary restorations are covered when included in the charge for the restoration process.
  25. Replacement of lost, stolen, or damaged dentures, except once every five years.
  26. Procedures, appliances, or restorations, other than those for replacement of structure loss from caries that are necessary to alter, restore, or maintain occlusion by any of

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the following: realignment of teeth, periodontal splinting, gnathological recordings, equilibration, treatment of disturbances of the temporomandibular joint (TMJ), orthognathic procedures.

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

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## GENERAL INFORMATION

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### **Plan Administration**

The self-funded Traditional Dental Plan is underwritten by Weber State University and administered by Educators Mutual Insurance Association of Utah.

### **Eligibility**

An Employee of Weber State University (WSU) and his or her Dependents are eligible for participation and coverage under this Plan if the Employee is a Full-time Employee of WSU or an Early Retiree. Dependents of the Employee eligible for coverage include unmarried Dependent children from birth to the 26<sup>th</sup> birthday, and the Employee's Spouse. Unmarried children may include stepchildren, children legally placed for adoption, and adopted children. A Dependent child's coverage may be extended beyond the 26<sup>th</sup> birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Participant for support and maintenance. The Participant must furnish written proof of disability and dependency to Educators, on behalf of WSU, within 31 days after the child reaches 26 years of age. Educators may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. (Please refer to Dependent in the "Definition of Terms" section for more information.)

### **Changes in Covered Person Information**

Participants should notify Educators, on behalf of WSU, within 31 days whenever there is a change in a Covered Person's situation that may affect the Covered Person's enrollment eligibility or status.

### **Enrollment**

To enroll, the Employee must complete an enrollment application and file it with WSU within 31 days of his or her employment date, or during a subsequent Open Enrollment Period. Generally, a Participant is not entitled to change his or her coverage elections during the Plan Year, except as provided in the *Special Enrollment* section.

### **When Coverage Begins**

If the Employee enrolls within 31 days of his or her employment, the Employee's coverage (and the coverage of his or her eligible Dependents, if such Dependents were also enrolled during such 31-day period) becomes effective on the date of hire.

If the Employee enrolls during an Open Enrollment period that is more than 31 days after his or her date of hire, the Employee's coverage (and the coverage of eligible Dependents, if such Dependents were also enrolled during such Open Enrollment period) becomes effective the first day of the following Plan Year.

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

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## Special Enrollment

### Special Enrollment Period When Other Coverage Terminates

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

When the Employee declined enrollment for himself or herself and/or his or her eligible Dependents, the Employee and/or his or her eligible Dependents were covered under a group health plan or had health insurance coverage, and

- (1) If the other coverage was COBRA continuation coverage, such continuation coverage has since been exhausted; or
- (2) If the other coverage was not under COBRA, either the other coverage has been terminated as a result of loss of eligibility of coverage or employer contributions towards such coverage have been terminated. (Note: Loss of eligibility of coverage includes a loss due to legal separation, divorce, death, termination of employment, reduction in hours worked, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or intentional misrepresentation.)

If the Employee meets the above conditions, he or she may elect coverage for himself or herself and/or his or her eligible Dependents by making an election with WSU, in the manner prescribed by WSU, within 31 days of such cessation. If the Employee makes a timely election, coverage will be effective as of the date such coverage ceased.

### Special Enrollment Period for Acquisition of Dependent

The Employee and/or his or her new eligible Dependent may enroll for coverage (even if he or she previously declined coverage for himself or herself and/or his or her eligible Dependents) if the Employee acquires such new eligible Dependent due to marriage (including children of the new Spouse), birth, adoption, or placement for adoption. In addition, the Employee may also enroll his or her Dependent Spouse if the Employee acquires a new Dependent due to marriage, birth, adoption, or placement for adoption. To enroll during this Special Enrollment period, the Employee must enroll within 30 days of the event.

Coverage for the newly acquired Dependent will be effective as follows:

- (1) In the case of marriage, the marriage date; or
- (2) In the case of an eligible Dependent's birth, adoption, or placement for adoption, the date of such birth, adoption, or placement for adoption.

### Termination of Coverage

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

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- For the Participant and covered Dependents, the date of the Participant's termination of employment or when the Participant's employment position or status changes such that he or she is no longer a Full-time Employee, except in the case of Early Retirees;
  - The Participant and covered Dependents, the last day of the month for which coverage has been paid, subject to a 30-day Grace Period, in the event any required Participant contributions are not made;
  - For covered Dependents, other than the Participant's Spouse, the individual ceases to be an eligible Dependent when either of the following occurs:
    - a. The date the Dependent is married; or
    - b. The last day of the calendar month coinciding with the Dependent's 26<sup>th</sup> birthday;
  - For covered Spouse, the date the divorce from the Subscriber is final;
  - For the Participant and covered Dependents, the effective date of any election by the Participant to cease coverage for the Participant and/or his or her Dependents;
  - For the Participant and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
  - For the Participant and covered Dependents, the date this Plan is terminated; or
  - For any Covered Person, the discovery of fraud or misrepresentation on the part of the Covered Person in either the enrollment process or in the use of services or facilities under the terms of the coverage, including any misuse of a Plan ID card. (Note: If a Covered Person's coverage is terminated under this provision, the termination of coverage will relate back to the effective date of coverage and Educators may recover any overpayments from the Covered Person such that Educators and the Covered Person are returned to the same financial position as if no coverage had ever been in force. Termination of a Participant's coverage for cause will also result in the termination of coverage of the Participant's covered Dependents.

### **Family Medical Leave Act (FMLA)**

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

- A Participant may continue his or her coverage and the coverage of his or her covered Dependents during an FMLA leave provided he or she continues to pay any required Employee portion of the cost of coverage in accordance with WSU's FMLA leave policy. WSU will continue to make the same contributions toward that coverage that it would have made had the Participant not taken FMLA leave.
- If the Employee portion of the cost of coverage is not paid, the Participant's and Dependents' coverage will be terminated 31 days after the due date of any required payment. Upon the Participant's return to work, the Participant's coverage and the coverage of any previously covered Dependents, will be reinstated as long as the Participant returns to work before or following the expiration of the FMLA leave. If the Participant does not return to work before or following the expiration of the FMLA

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leave, the Participant will be treated as a new Employee upon his or her return and will be entitled to elect coverage for himself or herself and his or her eligible Dependents in accordance with the rules applicable to new Employees.

### **Military Leave**

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), a Participant who is on military duty with a uniformed service has certain rights. If the period of duty is less than 31 days, coverage will be maintained if the Subscriber pays any required Subscriber contribution. If the period of duty is for more than 31 days, WSU must permit the Subscriber to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 18 months or the period of duty. A Subscriber receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period or Preexisting Condition Limitation exclusion can be imposed on a returning Subscriber and his or her Dependents if the period or exclusion would have been satisfied had the Subscriber’s coverage not terminated due to the duty leave.

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

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

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## CONTINUATION OF COVERAGE

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### COBRA Continuation of Coverage Requirements

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

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

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

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

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

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Subsequent premiums must be paid by the first of each month. Failure to pay this premium within 31 days of the premium due date for any month will result in cancellation of all coverage(s), *without notice*. Any claims received for services rendered during the 31-day Grace Period will be held for processing until premium payment is received.

- **Period of Continuation Coverage.** If elected, the maximum period for continued coverage for a “qualifying event” involving termination of employment or reduced working hours is 18 months. For all other “qualifying events,” the maximum period is 36 months. Other events will cause coverage to end sooner and this will occur on the earliest of any of the following:
  - The date WSU ceases to provide any group health plan to any Employee;
  - The date the Covered Person fails to make any required premium payment; or
  - The date the Covered Person becomes either of the following:
    - A covered Employee under any other group health plan that does not contain any exclusion or limitation with respect to any Preexisting Condition the Covered Person has, or
    - Entitled to Medicare.
  
- **Extension of Coverage for Disabled Individuals.** If a Covered Person is disabled according to Social Security any time within the first 60 days of COBRA coverage (or a qualifying new child is so disabled within 60 days of the birth, adoption, or placement for adoption), the Covered Person may extend the 18 months COBRA coverage period to 29 months from the termination date or reduction in hours date. This extension may apply independently to each qualified Covered Person regardless of whether the disabled individual is covered under a COBRA election.

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

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

COBRA coverage will end the earliest of the following:

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

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## COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

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### Coordination with Other Group Plans

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

Any COB Plan that does not contain a coordination of benefits provision will be considered primary.

If a person is covered by two COB Plans that both have a coordination of benefits provision, the order of payment will be as follows:

- A COB Plan that covers a person as an employee (including early retirees, if applicable) will be primary over a COB Plan that covers the same person as a Dependent, retiree, or laid-off individual.
- A COB Plan covering a person as a Dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birthday (month and day) in the year. If both parents have the same birthday, the COB Plan covering the child for the longer period of time will be primary.
- If the other COB Plan does not have the 'birthday' rule, but instead has a rule based upon the gender of the parent, and if, as a result, the coordinating plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
- When the parents are legally separated or divorced, and if there are two or more COB Plans covering a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  1. First, the COB Plan of the parent with custody of the child;
  2. Then, the COB Plan of the Spouse of the parent with custody of the child; and
  3. Finally, the COB Plan of the parent not having custody of the child.

If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that COB Plan are determined first. The COB Plan of the other parent shall be the secondary COB Plan. This paragraph does not apply with respect to any claim determination period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules outlined in the second bullet above will apply.

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- If the preceding rules do not establish an order of benefit determination, the benefits of a COB Plan that has covered the person for the longer period of time will be primary over a COB Plan that has covered the person for a shorter period of time.

To determine the length of time a person has been covered under a COB Plan, two COB Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

The start of a new COB Plan does not include any of the following:

- A change in the amount or scope of a COB Plan's benefits.
- A change in the entity which pays, provides, or administers the COB Plan's benefits.
- A change from one type of COB Plan to another, such as from a single employer COB Plan to that of a multiple plan.

The claimant's length of time covered under a COB Plan is measured from the claimant's first date of coverage under that COB Plan. If that date is not readily available, the date the claimant first became a Participant or Covered Person of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present COB Plan has been in force.

When the Plan is primary, the benefits of another COB Plan will not be considered for the purpose of determining the benefits under this Plan.

The primary COB Plan must pay or provide its benefits as if the secondary COB Plan or plans did not exist. 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.

Whenever payments that should have been made under this Plan have been made under any other COB Plan, WSU 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 WSU will be fully discharged from liability under this Plan to the extent of the payment.

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

- Any person to, or for whom, such payments were made.
- Any other insurance companies.
- Any other organization.

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

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

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

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

### **Internal Coordination of Benefits**

When a husband and wife are both eligible for group coverage under plans administered by Educators, as Employees of the same or different Plan Sponsors, the person whose birthday comes first in the year must enroll in the Plan for self, Spouse, and eligible Dependents; the other may enroll for self only, but include Spouse and all eligible Dependents on the enrollment form. Under this arrangement, full coordination of benefits, not to exceed the Table of Allowances, will be extended to all eligible members of the family according to the definitions of this Plan.

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

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## CLAIMS PROCEDURE

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Except as otherwise provided in this policy or by Utah law, no benefits provided under this policy shall be paid to, or on behalf of, a Covered Person unless the Covered Person, or his or her authorized representative, has first submitted a written claim for benefits to Educators, on behalf of WSU. Claims may be submitted at any time within 12 months of the date the expense is incurred. If, however, the Covered Person shows that it was not reasonably possible to submit the claim within that time period, then a claim may be submitted as soon as reasonably possible. The Plan may deny an untimely claim.

### How to File a Claim

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

EDUCATORS MUTUAL INSURANCE ASSOCIATION OF UTAH  
852 East Arrowhead Lane  
Murray, Utah 84107-5298

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

### Requests for Additional Information

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

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

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

### Exhaustion of Administrative Remedies

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

### Claims Review Process

1. The Covered Person may request a review of any claim decision adverse to the Covered Person, in whole or in part, by sending a written request to the **Educators Claims Review Committee**. This request must be received within 60 days after the Covered Person receives notice of the adverse decision. As part of this process, the

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Covered Person should review all pertinent information regarding the claim and explain, in writing, his or her reasons for believing the claim should have been granted. The Covered Person should also include any additional information that will aid the Claims Review Committee in reviewing the claim. Upon receipt of the request, the Covered Person may be contacted by Educators' member advisor. The Claims Review Committee is composed of at least three employees of Educators who did not participate and are not supervised by any person who participated in the initial decision. The Claims Review Committee will inform the Covered Person, in writing, of its decision. If the previous decision on payment of the claim stands, in whole or in part, the Covered Person will be given a specific reason for the decision

2. If the Covered Person does not agree with the findings of the Claims Review Committee, in whole or in part, the Covered Person may request a review regarding the disputed claim and an in-person hearing by the **Educators Board of Directors**. This request must be in writing and must be received by Educators, on behalf of the Plan Sponsor, within 30 days after the date of the letter indicating the decision of the Claims Review Committee. The Educators Board of Directors will inform the Covered Person of its decision and, if adverse to the Covered Person, the basis of its decision.

### **Arbitration**

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

The Covered Person may initiate arbitration proceedings by giving written notice to Educators, on behalf of the Plan Sponsor, of the election to proceed with binding arbitration. A failure to give such notice for more than 30 days after the delivery in writing of the final adjudication from the Claims Review Process shall be deemed to be an acceptance of the said final adjudication as a final and binding adjudication.

The procedures and rules governing the requested arbitration proceeding shall be (1) the terms of this Plan governing arbitration and the procedures for the same, and (2) the Utah Arbitration Act (Utah Code Ann. 78-31a-1 et seq). In the event of any inconsistency between the listed procedures and rules, the earlier listed provisions shall govern over the later listed provisions.

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

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All costs of the arbitration proceeding shall be borne equally by the Covered Person and Educators, on behalf of WSU. Upon request by the selected arbitrator, each party will deposit in advance with the selected arbitrator a sum sufficient to cover the reasonably estimated costs of the arbitration proceeding payable to the arbitrator with respect to the conduct of the arbitration proceeding. Any failure to deposit such sums in the time frame required shall entitle the other party to the entry by the arbitrator of a default award in favor of such non-defaulting party in accordance with the relief requested by such non-defaulting party. The parties agree that the award may not include attorneys' fees incurred, regardless of the fact of whether that party prevails in the arbitration proceeding. In other words, the Covered Person and Educators, on behalf of WSU, are each responsible for any attorneys' fees incurred by either of them in connection with the claim, controversy, or dispute, whether before, during, or after the arbitration proceeding. The decision and award of the arbitrator shall be final and binding upon the parties.

### **Subrogation and Recovery**

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

- The Covered Person must reimburse the Plan, up to the amount of such benefits advanced or paid by the Plan, out of any recovery obtained by the Covered Person from the third party (or such party's liability insurance) by judgment, settlement, or otherwise, whether or not the Covered Person is or has been made whole. The Plan is entitled to the first dollar of any recovery by the Covered Person and each dollar thereafter up to the amount of benefits advanced or paid by the Plan for the injuries to the Covered Person that were caused by the third party.
- The Covered Person cannot limit or avoid such reimbursement obligation to the Plan by any agreement with the third party or any assignment or designation of such proceeds.
- The Covered Person must not release or discharge any claims that the Covered Person may have against any potentially responsible parties without written permission from the Plan.
- The Covered Person must fully cooperate with WSU (including, but not limited to, executing all required instruments and papers), if the Plan chooses to pursue its own right of Subrogation against the third party; the Plan's right of Subrogation is limited to the amount of benefits advanced or paid by the Plan to or on behalf of the Covered Person as a result of the fault of the third party, and the Plan's right to recover such benefits from the third party does not depend upon whether the Covered Person is made whole by any recovery.

### **Benefit Accumulations**

All Deductibles, benefit limits, etc., except for the Lifetime Maximum Benefit, accumulate on a Contract Year basis, beginning July 1, and ending June 30.

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## DEFINITION OF TERMS

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**Accident** or **Accidental Injury**, for which benefits are provided, means Accidental bodily Injury sustained by the Member 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 Member 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.

**Adult**, for purposes of immunizations, means an individual who has reached his 19<sup>th</sup> birthday.

**Allowable Expenses**, when used in conjunction with coordination of benefits, means the amount on which the Plan would base its benefit payment for covered services in the absence of any other coverage. The difference in cost between a private Hospital room and a semi-private Hospital room is not considered an Allowable Expense under this definition, unless the Member's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice.

**Allowable Fee** means the schedule for payment of Eligible Expenses established by Educators.

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

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

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

**COB Plan** means a form of coverage with which coordination of benefits is allowed. These COB Plans include the following:

- Individual, group, or health maintenance organization (HMO) insurance coverage providing Hospital expense or medical surgical expense benefits, except those included in the following paragraph.
- Another group plan covering a Member.
- Group, group-type, and individual automobile "no-fault" medical and underinsured motorist payment contracts.
- Another self-funded employee welfare benefit plan.
- Medicare or other governmental programs, except those included in the following paragraph and any coverage required or provided by any statute.

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

- Hospital indemnity policies.
- Disability income protection.
- Accident-only policies.
- Specified disease or specified Accident policies.
- Nursing home or long-term care policies.
- Any state plan under Medicaid.
- Any law or plan when, by state or federal law, its benefits are in excess of those of any private insurance or other non-governmental plan.
- Medicare supplement policies.

The term COB Plan is construed separately with respect to each 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.

**Coinsurance** means the percentage of eligible charges payable by a Member directly to a Provider for covered services. Coinsurance percentages are specified on the “Summary of Benefits” chart.

**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 Member has satisfied any applicable Deductible and paid Eligible Expenses, including copayments, up to the Coinsurance Maximum, Educators 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 Plan Year. The Participating Provider and Non-participating Provider Options each have a separate Coinsurance Maximum.

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

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

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

**Custodial Care** means maintenance of a Member 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.

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

**Deductible** means the amount paid by a Member for Eligible Expenses from the Member's own money before any benefits will be paid under this Plan. *Deductibles* are not considered a Coinsurance Maximum expense.

**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 and legally adopted children) to their 26<sup>th</sup> birthday, who are not married and are dependent on the Subscriber for support and maintenance. 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 Educators within 31 days after the child reaches 26 years of age. Educators 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 legally 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.
- 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.

**Early Retiree** means a retired WSU Employee, who is between the ages of 55 and 64 at retirement, and who has at least 15 years of service with WSU. Early retirement ends on the fifth anniversary of the retirement date or when the Early Retiree reaches age 65, whichever comes first.

**Educators** means Educators Health Care, Inc.

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

**Eligible Expenses** means those charges incurred by the Member for Illness or injury that meet all of the following conditions:

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- 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 Educators Summary of Benefits or Table of Allowances for the services performed or materials furnished.
  - Are not excluded from coverage by the terms of this Plan.
  - Are incurred during the time the Member 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.

**Employee** means any person who is an employee or an elected or appointed officer of WSU. References to "Employee" also include Early Retirees.

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

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

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment, or procedure (or the patient informed consent document utilized with the drug, device, treatment, or procedure) was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- If Reliable Evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going research, Experimental study, or Investigational arm of an on-going phase III clinical trial, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

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

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**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 20 hours per week 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 WSU. References to “Full-time Employee” also include Early Retirees. For purposes of this Plan, Full-time Employee shall not include any individual who is classified as a leased employee or independent contractor by WSU, even if such individual is subsequently determined to be, or to have been, a common law Employee of WSU

**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; however, any claims received for services rendered during the Grace Period will be held for processing until policy charges are paid in full. In no event shall the Grace Period extend beyond the date the policy terminates.

**Home Health/Skilled Nursing Care** means medical care and treatment rendered to a sick or injured Member in the Member’s home, when the Member is unable to leave his home, is completing treatment that was initiated in the Hospital, and/or hospicecare in the final months of life, by a nurse under the written order and general supervision of the Member’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 licensed Hospital facility providing 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.

**Incidental Surgical Procedure** means a surgical procedure that does not add significant time or complexity to Member care.

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

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

**Intensive Care Room** means a Hospital section, ward, or wing that operates exclusively for critically ill Members 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.

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

**Life-threatening Condition** means an episode or incident where delay in treatment would jeopardize the Member'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.

**Lifetime Maximum Benefit** means the maximum amount of benefits paid by Educators, including the "Prescription Drug Program," that will be allowed under this Plan whether accumulated under this Plan or any combination of policies administered by Educators. There is one Lifetime Maximum Benefit shared by both the Participating Provider and Non-participating Provider Options.

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

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

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

When a medical question-of-fact exists, Medically Necessary or Medical Necessity shall include the most appropriate available supply or level of services 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.

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

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

**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.

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***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 WSU, during which an Employee may apply for insurance coverage for himself or herself or his or her Dependents.

***Other Limited Benefits*** means those limited benefits provided by the Plan that are available only if specific medical criteria, established by Educators are met. The portion the Member pays for these benefits **does not** apply toward the Coinsurance Maximum.

***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 Members 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 license, i.e., physician, oral surgeon, Dentist, anesthetist, etc., or a facility operating within the scope of its license, who has contracted with Educators 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 Member is confined in a medical facility on an Inpatient basis.

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

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

***Preexisting Condition*** means a condition (regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the six months prior to the enrollment date. Preexisting Condition also means a disability which is the result of a complication of a Preexisting Condition. Please refer to the *Preexisting Condition Limitation* section of this Plan for information on the benefit restrictions that may be imposed on some Preexisting Conditions.

***Preexisting Condition Limitation*** means the time Members must wait after enrolling in a new plan before they can be covered for some Preexisting Conditions. Please refer to the *Preexisting Condition Limitation* and *Waiver of Preexisting Condition Exclusion* sections of this policy.

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

**Prosthesis** means an artificial substitute for a missing body party, 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 rather than a medical diagnosis code or a well visit procedure code.

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

**Significant Medication** means a new drug with the FDA New Drug Application (NDA) classification of 1P that represents an important therapeutic advance and is the only medication available to treat a disease or condition as supported by at least one of the following sources: United States Pharmacopeia Drug Information, American Hospital Formulary Service Drug Information, findings and guidelines developed by federal government agencies or peer-reviewed literature. A medication that is approved or used for multiple diseases or conditions, but is the only available medication to treat a particular, narrow-niche indication is not included in this category.

**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 or she has experienced a qualifying event (including marriage, divorce, birth, adoption, placement for adoption, or loss of other insurance coverage) under HIPAA regulations. The Subscriber must complete and submit a new enrollment form and submit it to Educators 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 Educators has by virtue of this contract, and also by virtue of common law, to recover from a third party monies that Educators has advanced or paid to or on behalf of a Member, where such monies were paid as a result of an injury to the Member that was the fault of the third party.

**Subscriber** means the individual employed by WSU and enrolled with the Plan to receive covered services, through whom Dependents may also be enrolled with the Plan. Subscribers are also Members. The term Subscriber may include eligible early retirees.

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**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 Eligible Expenses established by Educators. The schedule of payment is used for all Providers regardless of their panel status.

**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**, during the waiting period and for the first 24 months of disability, 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 of medical care or treatment, if the application of the time periods for making non-urgent care determination (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 any Urgent Preauthorization Request if a physician with knowledge of the claimant's medical condition determines it to be one.

**WSU** means Weber State University.