This amendment is attached to and made a part of the Educators Mutual Insurance Association of Utah Premier Copay Dental Plan (the Plan) between Utah State University - College of Eastern and Educators Mutual Insurance Association of Utah (hereinafter EMI Health) effective July 1, 2019.

1. Remove the EMI Health address throughout the Plan and replace it with the following:

   5101 S. Commerce Dr., Murray, Utah 84107

2. Remove the reference to Summary of Benefits and replace it with the following:

   Schedule of Benefits

3. Waiting Periods. Remove the Waiting Periods section in its entirety and replace with the following:

   No benefit will be provided for Type 3 (major) or Type 4 (orthodontic) services during the first 12 months of coverage under this Plan. The waiting period will be waived for Employees and Dependents who are covered on the Employer’s previous dental plan and are enrolled on the effective date of this Plan. Employees and Dependents who enroll after the effective date of this Plan will be given credit for prior dental coverage, if there has been no break in coverage. Proof of prior coverage must be provided to EMI Health to receive waiting period credit. Failure to enroll at first opportunity results in a 12 month waiting period.


5. Dental Plan Exclusion. Remove exclusion 6 in its entirety and replace it with the following:

   #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.

6. Dental Plan Exclusion. Remove exclusion 14 and replace it with the following:

   #14. Care, supplies, treatment, and/ or services for any Injury or illness which incurred while taking part or attempting to take part in an Act of Aggression or an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental conditions).
7. **Special Enrollment Period for Acquisition of Dependent.** Remove the **Special Enrollment Period for Acquisition of Dependent** section in its entirety and replace it with the following:

The Employee and/or his new eligible Dependent may enroll for coverage (even if He previously declined coverage for himself and/or his eligible Dependents) if the Employee acquires such new eligible Dependent due to marriage, birth, adoption, or placement for adoption. In addition, the Employee may also enroll his Dependent Spouse if the Employee acquires a new Dependent due to marriage, birth, adoption, or placement for adoption. To enroll during this Special Enrollment period, the Employee must enroll within 31 days of the event (e.g., marriage, birth, adoption, or placement for adoption). Coverage will be effective as follows:

1. In the case of marriage, the marriage date; or
2. In the case of an eligible Dependent’s birth, the date of such birth; or
3. In the case of adoption, or placement for adoption, the coverage for an adopted child of a Participant is provided from the moment of birth, if placement for adoption occurs within 30 days of the child’s birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child’s birth.

8. **Termination of Coverage.** Remove the **Termination of Coverage** section in its entirety and replace it with the following:

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

For the Participant and covered Dependents, coverage will end on the 16th of the month if employment termination occurs between the 1st and the 15th of the month, or the 1st day of the following month if employment termination occurs between the 16th and last day of the month, or the date specified by the Employer, except, nine month base Employees who terminate at the end of the academic year are covered through the last day of the month in which the academic year is completed and retiring Employees are covered through the last day of the month in which they retire;

- For the Participant and covered Dependents, the last day of the month for which coverage has been paid, in the event any required Participant contributions are not made (subject to the 31-day Grace Period);
  - For covered Dependents, other than the Participant’s Spouse, the individual ceases to be an eligible Dependent on the last day of the calendar month coinciding with the Dependent’s 26th birthday;
  - For covered Spouse, the date the divorce from the Participant is final;
  - For the Participant and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
  - For the Participant and covered Dependents, the date this Plan is terminated; and
  - For any Covered Person, the discovery of fraud or intentional material misrepresentation of material fact on the part of the Covered Person in either the enrollment process or in the use
of services or facilities, including any misuse of a Plan ID card. (Note: If a Covered Person’s coverage is terminated under this provision based on fraud, the termination of coverage will relate back to the effective date of coverage and EMI Health may recover any overpayments from the Covered Person such that EMI Health and the Covered Person are returned to the same financial position as if no coverage had ever been in force. If the Covered Person’s coverage is terminated under this provision based on intentional material misrepresentation of material fact, the termination of coverage will relate back to the date the misrepresentation occurred and EMI Health may recover any overpayments from the Covered Person. Termination of a Participant’s coverage for cause will also result in the termination of coverage of the Participant’s covered Dependents.)

A Participant is not entitled to voluntarily terminate coverage for himself or his covered Dependents during the plan year, unless He experiences a Special Enrollment qualifying event (e.g. marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). If the Participant experiences a Special Enrollment qualifying event He may elect to terminate coverage for himself and/or his Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor, within 30 days of such event.

9. **Coordination of Benefits with Other Group Plans.** Remove the *Coordination of Benefits with Other Group Plans* section in its entirety and replace it with the following:

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

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

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

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

When this Plan is secondary, EMI Health will calculate the benefits the Plan would have paid on the claim in the absence of other health coverage and apply that amount to any Allowable Expense under the Plan that is unpaid by the Primary Plan. Payment will be reduced so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all COB Plans for the claim do not exceed 100 percent of the Allowable Expense for that claim. The Plan will create to the Deductible any amounts that would have been credited to the Deductible in the absence of other health care coverage.

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

- If this Plan is the Primary Plan, the Plan will pay or provide its benefits on a primary basis;
- If this Plan is the Secondary Plan, EMI Health will pay or provide its benefits first, but the amount of the benefits payable will be determined as if it were the Secondary Plan. Such
payment shall be the limit of EMI Health’s liability, and if the other COB Plan does not provide the information needed by EMI Health to determine its benefits within a reasonable time after it is requested to do so, EMI Health will assume that the benefits of the other plan are identical to this Plan, and will pay its benefits accordingly. However, if within three years of payment, EMI Health receives information as to the actual benefits of the Non-conforming Plan, the Plan will adjust any payments accordingly.

- If the Non-conforming Plan reduces its benefits so that the Covered Person receives less in benefits than he or she would have received had the Plan paid or provided its benefits as the secondary COB Plan and the Non-conforming Plan paid or provided its benefits as the primary COB Plan, then EMI Health shall advance to or on behalf of the Covered Person an amount equal to such difference.
  - In no event will the Plan 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, the Plan shall be subrogated to all rights of the Covered Person against the Non-conforming Plan in the absence of Subrogation.

- If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the Primary Plan.

Whenever payments that should have been made under this Plan have been made under any other COB Plan, the Plan Sponsor or EMI Health may, at its own discretion, pay any amounts to the organization that has made excess payments to satisfy the intent of this provision. Amounts paid will be regarded as benefit payment, and the Plan Sponsor and EMI Health will be fully discharged from liability under this Plan to the extent of the payment.

It is important for the Covered Person to take responsibility in reporting to EMI Health any changes in the status of other insurance coverage.

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

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

Certain facts may be needed in order to apply COB rules. These facts may be obtained from, or provided to, any other organization or person, subject to applicable privacy laws. Each person claiming benefits under this Plan will be required to give the Plan Sponsor and EMI Health any facts needed to pay a claim.
10. **Claims Audit.** Remove the *Claims Audits* section in its entirety and replace it with the following:

In addition to the Plan’s dental record review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed Eligible Expenses and/or are not Medically Necessary and reasonable, if any, and may include a patient medical billing records review and/or audit of the patient’s medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of Eligible Expenses or other applicable provisions, as outlined in this Plan Document.

Despite the existence of agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accordance with the terms of this Plan Document.

11. **Claims Review Process.** Remove the *Claims Review Process* section in its entirety and replace it with the following:

For and on behalf of Plan Sponsor, EMI Health will administer the following claims appeal process:

1. If a claim is denied, in whole or in part, a written notice (the “Denial Notice”) will be sent to the Covered Person within (a) 30 days after receiving the initial claim, or (b) 45 days after receiving the claim if EMI Health determines that such an extension is necessary due to matters beyond the control of the Plan and if EMI Health provides an extension notice during the initial 30-day period. If the extension is due to the Covered Person’s failure to submit information necessary to decide a claim, 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 Covered Person responds. The Covered Person has 45 days after receiving the extension notice to complete the claim. The denial notice will set forth the following:

   - The specific reasons the claim was denied.
   - Specific references to the pertinent plan provision on which the denial is based.
   - A description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed.
   - An explanation of the Plan’s claims review procedure.

2. The Covered Person may appeal an adverse claim decision, in whole or in part, by sending a written notice to the EMI Health Claims Review Committee (the “CRC”) which will review the initial adverse claim decision on behalf of the Plan Sponsor. This written appeal notice (the “Initial Appeal Notice”) must be received by the CRC within 180 days after the date the Covered Person received the Denial Notice. The initial appeal notice must include all pertinent information regarding the claim and must explain the reasons why the Covered Person believes the claim should have been granted, in whole or part.
The CRC will then review the initial adverse claim decision on behalf of the Plan Sponsor and shall inform the Covered Person in writing of its decision within 30 days of receipt of the written appeal. The Plan Sponsor will indemnify and hold the CRC harmless with respect to any such decision on appeal, except for intentional acts of the CRC which are clearly made in willful disregard of the rights of the Covered Person. A denial of a claim based on a reasonable interpretation of the provisions of the Plan shall not be considered to be an intentional act which is in willful disregard of the rights of a Covered Person.

3. If the Covered Person does not agree with the findings of the CRC, the Covered Person may further appeal any adverse claim decision, by sending a second written notice (the “Second Appeal Notice”) to the Plan Sponsor, Utah State University - College of Eastern Utah, Attention: Insurance Benefit Department. The second appeal notice must be received within 60 days after the date of the CRC decision. The second appeal notice should include all pertinent information regarding the claim and explain the reasons the Covered Person believes the claim should have been granted, in whole or part. The Plan Sponsor will then review the initial adverse claim decision and also the findings and decision of the CRC. The Plan Sponsor’s review and subsequent decision on such second appeal shall be based upon the provisions of the Plan documents in which the Covered Person was enrolled on the date of service of the claim(s) which is (are) subject to such second appeal. The Plan Sponsor will inform the Covered Person in writing of its decision on such second appeal within 30 days of receipt of the second appeal.

4. If the Covered Person does not agree with the findings of the Plan Sponsor and desires further review the Covered Person shall have a right to submit the matter to binding arbitration or to pursue any remedies available at law or equity or other legal remedy. The Covered Person must submit a written demand for arbitration within 180 days after the Covered Person receives notice of the adverse findings of the Plan Sponsor on the second appeal. Such arbitration will be conducted according to the Utah Arbitration Act. Venue for any court action to enforce an arbitration award or otherwise related to any claim for benefits shall be exclusively in Salt Lake County, State of Utah. The Plan Sponsor shall bear the costs of arbitration, filing fees, administrative fees, and arbitrator fees. Other expenses of arbitration including, but not limited to, attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses will be borne by the party incurring those expenses. The arbitration award shall not include attorney’s fees.

5. The Plan Sponsor shall have the exclusive right to interpret the terms of the Plan. The decision about whether to pay any claim of the Covered Person, in whole or in part, is within the sole discretion of the Plan Sponsor and such decision shall be final and conclusive.

6. The Covered Person shall have the burden of persuasion. He or she will have the right to examine all evidence presented to the CRC and to the Plan Sponsor and to question witnesses. It shall be in the discretion of the Plan Sponsor to decide whether to have a hearing on the appeal of the Covered Person. If a hearing is held, it shall be brief and informal, and shall not be conducted according to technical judicial rules of evidence. Rather, any relevant information may be submitted if, in the discretion of the Plan Sponsor, it is evidence upon which responsible persons generally rely.
12. **Independent Review.** Remove the *Independent Review* section in its entirety and replace it with the following:

If after exhaustion of the claims review process provided in this Plan, the Covered Person still disputes a determination of Medical Necessity, the Covered Person 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 EMI Health, the Plan, the Plan’s fiduciary, the Plan Sponsor, or any employee or agent of any of the foregoing, that does not have any material, professional, familial, or financial conflict of interest with EMI Health, any officer, director, or management employee of EMI Health, the Covered Person, the Covered Person’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.

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

If the Covered Person timely elects the above independent review, then EMI Health will inform the Covered Person, in writing, of the decision of the IRO, within 60 days after the date EMI Health received the Covered Person’s written request for independent review of Medical Necessity.
13. **Definition of Terms.** Remove the definition of Accident and Accidental Injury in its entirety and replace it with the following:

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

14. **Definition of Terms.** Remove the definition of Dentist in its entirety and replace it with the following:

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

15. **Definition of Terms.** Remove the definition of Dependent in its entirety and replace with the following:

*Dependent* means the Participant’s children (including stepchildren, legally adopted children, and children for whom the Participant has legal guardianship) to their 26th birthday. A child is considered a Dependent beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is dependent on the Participant for support and maintenance. The Participant must furnish proof of disability and dependency to EMI Health within 31 days after the child reaches 26 years of age. EMI Health may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. Dependent also refers to any of the Participant’s natural children, children legally placed for adoption, or adopted children for whom a court order or administrative order has dictated that the Participant provide coverage. Dependent also refers to the Participant’s Spouse. Dependent does not include an unborn fetus.
IN WITNESS WHEREOF, EMI Health has caused this Amendment to be executed this 1st day of July, 2019 at its office in Murray, Utah.

UTAH STATE UNIVERSITY - COLLEGE OF EASTERN

Doug Bullock
President
June 24, 2019
Date

Doug Bullock
Corporate Secretary
June 24, 2019
Date

EMI HEALTH