
INTRODUCTION

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

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

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

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

Regardless of benefits specified, this Plan will reimburse or pay any claim only if the services rendered are determined to be medically necessary. Determination of medical necessity is made by 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:

- 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 Educators plans or procedures, please call a Customer Service Representative between 8:00 a.m. and 5:00 p.m., Monday through Friday (MT):

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

Plan Administrator

This Educators Vision Plan is administered and underwritten by Educators Mutual Insurance Association of Utah.

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EDUCATORS VISION PLAN

Vision Examination

A vision examination is covered according to the “Summary of Benefits” chart. Vision examinations include these services:

- A case history.
- External examination of the eye and adnexa.
- Ophthalmoscopic examination.
- Determination of refractive status.
- Binocular balance testing.
- Tonometry test for glaucoma, when indicated.
- Gross visual fields testing, when indicated.
- Color vision testing, when indicated.
- Summary finding.
- Recommendations, including prescribing of corrective lenses.

Prescribed Lenses and Frames

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

Benefits for lenses and frames include the following directly related Provider services:

- Facial measurements and determination of interpupillary distance.
- Assistance in selection of frames.
- Procurement of lenses as prescribed.
- Verification of lenses as prescribed.
- Follow-up care for a reasonable period of time for fitting and adjustment of prescribed eyewear.

Contact Lenses

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

Benefit Maximums

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

Medically Necessary

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

All benefits will be paid as set forth in the “Summary of Benefits” chart. The Plan, regardless of benefits specified, will reimburse or pay any claim only if the services rendered are determined to be Medically Necessary. Determination of “medical necessity” will be made by Educators using its own set of criteria, or by an independent contractor appointed by Educators.

Coinsurance Payments

Educators will pay Eligible Expenses, less any applicable Coinsurance payments or Deductibles, as defined in this policy and shown on the “Summary of Benefits” chart.

Discounts, per diem, global fees, or any other arrangements entered into by Educators with Providers of services or products will not affect the Coinsurance payment responsibility of the Member.

VISION PLAN EXCLUSIONS

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

Educators Vision Plan does not pay for any of the following:

1. Expenses for preparing vision reports, itemized bills, or claim forms.
2. Diagnostic services, other than those provided as a component of a vision examination.
3. Drugs or medications not administered for the purpose of a vision examination.
4. Services, procedures, or supplies determined by the policy to be special or unusual including, but not limited to, orthoptics, vision training, and low vision aids.
5. Charges for non-prescription sunglasses or other special purpose non-prescribed vision aids.
6. Charges for duplicate or spare eyeglasses, lenses, frames, or contact lenses, even to replace lost, broken, or stolen lenses, frames, or contact lenses.
7. Eligible Expenses incurred before coverage under this policy begins or that extend after coverage under this policy ends.
8. Charges for vision care, services, or supplies resulting from participation in, or in consequence of having participated in, the commission of an assault or a felony.
9. Medical or surgical treatment, care, services, or procedures.
10. Illness or injury caused by the negligent or wrongful act of another, or for which the Member is covered by any workers' compensation or similar law; except that 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.
11. Illness or injury that a Member incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Member, except that Educators may elect to advance benefits to or on behalf of the Member in either situation, subject to Educators' rights of Subrogation and reimbursement set forth herein.
12. Illness or injury for which the Member is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, except as otherwise provided herein, or as otherwise required by law.

ELIGIBILITY AND PARTICIPATION

Plan Administration

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

Eligibility

An Employee and his Dependents are eligible for participation and coverage under the Plan if the Employee is a Full-time Employee of the Employer. Dependents of the Employee eligible for coverage include unmarried Dependent children from birth to the 26th birthday and the Employee's Spouse. Unmarried children may include stepchildren, children 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 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Subscriber for support and maintenance. The Subscriber must furnish written proof of disability and dependency to Educators within 31 days after the child reaches 26 years of age. 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. 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.)

Change 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 his Employer within 31 days of his employment date or as specified by the Employer, or during a subsequent Open Enrollment period.

When Coverage Begins

If the Employee enrolls within 31 days of his employment, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such 31-day period) becomes effective as determined by the Employer.

If the Employee enrolls during an Open Enrollment period, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such Open Enrollment period) becomes effective the first day of the following plan year.

Termination of Coverage

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

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- For the Subscriber and covered Dependents, the date determined by the Employer regarding the Subscriber's termination of employment or when the Subscriber's employment position or status changes such that He is no longer a Full-time Employee;
 - For the Subscriber and covered Dependents, the last day of the month for which coverage has been paid, in the event any required Subscriber contributions are not made (subject to the 30-day Grace Period);
 - For covered Dependents, other than the Subscriber's Spouse, the individual ceases to be an eligible Dependent when either of the following occurs:
 - The date the Dependent is married, or
 - The last day of the calendar month coinciding with the Dependent's 26th birthday;
 - For covered Spouse, the date the divorce from the Subscriber is final;
 - For the Subscriber and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
 - For the Subscriber and covered Dependents, the date this Plan is terminated; and
 - For any Member, the discovery of fraud or intentional material misrepresentation of a material fact on the part of the Member in either the enrollment process or in the use of services or facilities. (Note: If a Member's coverage is terminated under this provision based on fraud, the termination of coverage will relate back to the effective date of coverage and 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.)

Family Medical Leave Act (FMLA)

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

- A Subscriber may continue his coverage and the coverage of his covered Dependents during an FMLA leave provided the Subscriber continues to pay any required Employee portion of the cost of coverage in accordance with the Employer's FMLA leave policy. The Employer shall continue to make the same contributions toward that coverage that it would have made had the Subscriber not taken FMLA leave.
- If premiums are not paid, the Subscriber's and covered Dependents' coverage will be terminated 31 days after the due date of any required payment. Upon the Subscriber's return to work, the Subscriber's coverage and the coverage of any previously covered

Dependents will be reinstated as long as the Subscriber returns to work before or following the expiration of the FMLA leave. If the Subscriber does not return to work before or following the expiration of the FMLA leave, the Subscriber will be treated as a new Employee upon his return and will be entitled to elect coverage for himself and his eligible Dependents in accordance with the rules applicable to new Employees.

Military Leave

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), a Subscriber who is on military duty with a uniformed service has certain rights. If the period of duty is less than 31 days, coverage will be maintained if the Subscriber pays any required Subscriber contribution. If the period of duty is for more than 31 days, Educators must permit the Subscriber to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 24 months or the period of duty. A Subscriber receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period can be imposed on a returning Subscriber and his Dependents if the period would have been satisfied had the Subscriber’s coverage not terminated due to the duty leave.

Qualified Medical Child Support Orders

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

CONTINUATION OF COVERAGE

COBRA Continuation of Coverage Requirements

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

- **Qualifying Event.** A “qualifying event” is any of the following:
 - For an Employee, termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;
 - For a Spouse and eligible Dependents, death of the Employee;
 - For a Spouse, divorce or legal separation;
 - For a Spouse and eligible Dependents, loss of coverage due to the Employee becoming eligible for Medicare;
 - For a Dependent child, ceasing to qualify as a Dependent under the Plan;
 - For retirees and their Dependents, employer bankruptcy under Chapter 11.

COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

Coordination with Other Group Plans

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

Any COB Plan that does not contain a coordination of benefits provision will be considered primary. Refer to Plan document for full details on Coordination of Benefits with other group plans.

Internal Coordination of Benefits

Not all plans provide internal coordination of benefits. Please contact Educators for further details.

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

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

CLAIMS PROCEDURE

Except as otherwise provided in this policy or by Utah law, no benefits provided under this policy shall be paid to, or on behalf of, a Member unless the Member, or his authorized representative, has first submitted a written claim for benefits to 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 MUTUAL INSURANCE ASSOCIATION OF UTAH
852 East Arrowhead Lane
Murray, Utah 84107-5298

If the claim is for prescribed glasses or contact lenses, and there is no coded Provider bill, fill out the Employee portion of a claim form, attach the related receipts, and submit them to the above referenced address. Educators' Claims Department will supply claim forms. If the claim form is not properly completed, it cannot be processed, and it will be returned.

Requests for Additional Information

There are times when claims submitted in the Member's behalf may not contain sufficient information for 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 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 Educators or the plan administrator, and no arbitration request may be made, until the Member has exhausted the claims review process, as provided in this policy.

Claims Review Process

If Educators denies payment of a claim which a Member believes is properly compensable under the applicable terms of the Plan, the Member shall within the time limits provided in subparagraphs one through five below after receipt of notice of denial of payment or coverage take the matter up with **Educators' claims review committee**, which shall be 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. 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, 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.

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

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 such an extension is necessary due to matters beyond the control of the Plan 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.
3. The claims review committee will provide notice of its decision on appeal within 30 days after receiving the request for appeal.
4. If the claims review committee denies the claim in whole or in part, on appeal, the Member has 180 days after receiving notice of the denial to request a second level appeal in writing.
5. The board of directors will provide notice of its decision on the second level of appeal within 30 days after receiving the notice of appeal to the board.

Independent Review of Medical Necessity

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

The Member may initiate such independent review of Medical Necessity by giving written notice to 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.

Arbitration

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

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

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

Benefit Accumulations

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

DEFINITION OF TERMS

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

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

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

COB Plan, for coordination of benefits purposes, means a form of coverage with which coordination is allowed. These 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.
- Medicare or other governmental programs, except those included in the following paragraph, and any coverage required or provided by any statute.

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 policy, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a policy, contract, or other arrangement which is subject to a coordination of benefits provision, as separate from the portion which is not subject to such a provision.

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

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

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

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

Dependent means the Subscriber’s children (including stepchildren and legally adopted children) to their 26th 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. 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. 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 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.

Educators means Educators Mutual Insurance Association of Utah.

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

- Are necessary for care and treatment and are recommended by a Provider while under the Provider’s continuous care and regular attendance.
- Do not exceed the 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 policy.
- Are incurred during the time the Member is covered by this policy.

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

Employer means Policyholder.

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

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

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

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

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

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

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

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

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

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

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

Member means an eligible person who enrolled with Educators through the Employer's group to receive covered services and who is recognized by Educators as a Member. Employees/retirees of the Employer 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.

Plan means Educators Vision plan.

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

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

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

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

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 the Policyholder and enrolled with the Plan to receive covered services, through whom Dependents may also be enrolled with the Plan. Subscribers are also Members. The term Subscriber may include eligible early retirees.

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

Table of Allowances means the schedule for payment of Eligible Expenses established by Educators. The schedule of payment is used for all Providers regardless of their panel status.