Board of Governors' Executive Committee Meeting
Turner Family Conference Room, Carrington Hall 203
Wednesday, 9/20/2017
4:00 - 5:00 PM CT

I. Roll Call

II. Approval of Minutes
   II.A. Approval of Minutes of the Executive Committee Meeting of August 16 2017 - Page 2

III. President
   III.A. Approval of Revisions to Governing Policy G.5.02 Expressive Activity Policy - Page 5

IV. West Plains
   IV.A. Approval of Lease Agreement for the Lease of Property at 212 Harlin Drive, West Plains, Missouri - Page 9

V. Procurement and Financial
   V.A. Approval of Procurement Activity Report - Page 14

VI. Facilities and Equipment
   VI.A. Approval of an Intergovernmental Agreement Regarding Law Enforcement Services with Missouri State University for Fiscal Year 2018 - Page 18
   VI.B. Approval of a MOU Regarding Law Enforcement Services with Missouri State University for the Mountain Grove Campus - Page 28
   VI.C. Approval of Consultant and Authority to Enter into Agreements for Professional Services in Conjunction with the FCC Channel Reassignments to Television Stations KOZK and KOZJ - Page 32
   VI.D. Approval of Consultant and Authority to Enter into an Agreement for Professional Services in Conjunction with the Tower Reinforcement for the KOZK Television Station - Page 33
   VI.E. Approval of Lease Agreement for Radio Tower Space for KSMU-West Plains Between Missouri State University and Tom and Shawn Marhefka - Page 34
   VI.F. Approval to Enter Into Lease Agreement at Jordan Valley Innovation Center (JVIC) - Page 47
   VI.G. Approval of Bids and Award of a Contract for the Elevator Refurbishing at the Professional Building - Page 72

VII. Human Resources
   VII.A. Approval of Missouri State University Group Medical Plan - Page 74

VIII. Resolution Authorizing Closed Meeting, Pursuant to Sections 610.021(1), (2), (3), (6), (9), (11), (12), (13), (14) and/or (17) of the Revised Statutes of Missouri
      Closed Meeting Resolution - Page 171

IX. Adjournment
MINUTES OF THE EXECUTIVE COMMITTEE
OF THE BOARD OF GOVERNORS
MISSOURI STATE UNIVERSITY
AUGUST 16, 2017

1. Roll Call:

Present - Ms. Virginia Fry, Chair of the Board
Ms. Beverly Miller, Governor (by conference call)
Ms. Carrie Tergin, Vice Chair of the Board (by conference call)

Absent - Mr. Gregory Spears, Governor

Also Present - Mr. Clifton M. Smart III, President
Dr. Jim Baker, Vice President for Research and Economic Development & International Programs
Dr. Drew Bennett, Chancellor of the West Plains Campus (by conference call)
Mr. Keith Boaz, Senior Associate Athletic Director, Athletics & Entertainment
Ms. Donna Christian, Director of Internal Audit and Compliance
Dr. Julie Combs, Department Head, College of Arts and Letters
Mr. Ryan DeBoef, Chief of Staff and Assistant to the President for Governmental Relations
Ms. Rachael Dockery, General Counsel
Mr. Steve Foucart, Chief Financial Officer
Dr. Cameron LaBarr, Director of Choral Studies
Mr. Robert Moore, Associate Director, Financial Aid
Mr. Matt Morris, Vice President for Administrative Services
Mr. Jeff Morrissey, Chief Information Officer
Ms. Hillary Roberts, Senior Instructor, Biomedical Sciences
Ms. Suzanne Shaw, Vice President for Marketing and Communications
Dr. Dee Siscoe, Vice President for Student Affairs
Ms. Lauren Webster, Associate Director for Planning, Design & Construction
Mr. Mike Wills, Director for Procurement
Mr. Ryan Wilson, Past Chair, Staff Senate
Ms. Kristan Gochenauer, Secretary of the Board

2. Presiding – Ms. Virginia Fry, Chair of the Board of Governors, called the Executive Committee conference-call meeting to order at 4:00 p.m. in Room 203 of Carrington Hall on the campus of Missouri State University in Springfield, Missouri.

3. Approval of Minutes – Ms. Fry mentioned that the first item of business was the approval of the minutes for the open meeting of July 19, 2017. Ms. Carrie Tergin so moved, receiving the second of Ms. Beverly Miller.

Motion passed 3-0.
4. **Procurement and Financial** – Mr. Steve Foucart, Chief Financial Officer, presented a resolution summarizing Procurement Services’ Office activities from July 14, 2017 through August 11, 2017 (Purchasing Activity Report No. 457-17). The six items included in the resolution were:

- Approval requested for an apartment lease for dietetic internships. Rental units are located at 733 Cardinal Drive, Webb City, Missouri. Leases are for a twelve month period, August 24, 2017 through April 2, 2018, at a total cost of $5,310.

- Approval recommended to continue utilization of The Interlocal Purchasing System (TIPS) cooperative contract, Contract 3072210, with En Pointe Technology to administer the Microsoft Campus Agreement. This would be a one-year extension for September 1, 2017 through August 31, 2018 at a total cost of $134,739.96.

- Approval recommended to purchase Chalk & Wire’s CW Pro, a portfolio-enabled education assessment platform for the West Plains campus. The estimated cost of $144,000 will be paid through student fees.

- Approval requested for housing lease services with Bryan Properties for the University’s International Leadership and Training Center (ILTC). For fall 2017 and spring 2018, estimated cost is $165,375.

- Approval recommended for extension of Contract C6700-1 with Kyer Product Visions Incorporated for governmental consulting services for Jordan Valley Innovation Center (JVIC) Development. Contract extension is for one year, October 1, 2017 through September 30, 2018, with two possible one-year renewal periods at a total estimated cost of $195,000 for all three years.

- Approval requested to issue a purchase order to Perform International for travel arrangements and related services for the University Chorale May 19, 2018 through June 6, 2018. Funding to be from participating students with additional funds requested from the College of Arts and Letters for an estimated total of $197,225. A motion was made and seconded, respectively, by Ms. Miller and Ms. Tergin. Motion passed 3-0.

5. **Facilities and Equipment** – Mr. Matt Morris, Vice President for Administrative Services, presented a resolution for the approval to grant a license agreement with Hillyard, Inc. to install restroom toilet paper dispensers at the John Q. Hammons Arena, John Q. Hammons Student Center, Robert W. Plaster Stadium, Juanita K. Hammons Hall for the Performing Arts, Betty and Bobby Allison North Stadium, and Betty and Bobby Allison South Stadium Agreement No. 395-17). Hillyard, Inc. may contract with an independent third party to install the dispensers at their expense. Work will be completed by September 2017. A motion was made by Ms. Tergin and seconded by Ms. Miller. Motion passed 3-0.
6. **Adjournment** – Ms. Fry adjourned the conference-call meeting at 4:18 p.m. on the motion of Ms. Miller, the second of Ms. Tergin, and the unanimous vote of the committee.

Kristan E. Gochenauer
Secretary of the Board
Recommended Action – Approval of Revisions to Governing Policy G.5.02 Expressive Activity Policy

The following resolution was moved by ________________________________ and seconded by ________________________________.

WHEREAS, Missouri State University is committed to providing an environment where issues can be openly discussed and explored;

WHEREAS, Missouri State University’s G.5.02 Expressive Activity policy is in place to provide a community environment in which open discussion can occur without disrupting the academic mission or daily University functions subject to constitutional time, place, and manner limitations and without unconstitutionally interfering with the rights of others; and

WHEREAS, in an effort to promote a safe and orderly campus atmosphere, Administration recommends that the G.5.02 Expressive Activity Policy be revised to provide additional time, place, and manner limitations to expressive activity subject to the Policy.

WHEREAS, the proposed revisions to G.5.02 Expressive Activity Policy are set forth in the attached Schedule 1.

NOW THEREFORE, BE IT RESOLVED by the Board of Governors for Missouri State University authorize the requested revision to policy G.5.02.

VOTE: 

AYE _____

NAY _____

NOTES:

Pursuant to the proposed revisions, participants would be prohibited from carrying weapons of any kind (as defined by state law), ammunition, explosives, body armor, helmets, mace/pepper spray, masks, torches, vehicles, and any other item identified by the University policy, Op1.01-1, as increasing the risk of injury to the campus community or event attendees.

The proposed revisions would also limit the time of expressive activity to four (4) hours in a twenty-four (24) hour day. The prior version of G.5.02 limited the time of expressive activity to eight (8) hours in a twenty-four (24) hour period.

Finally, the proposed revisions to G.5.02 would limit the place and manner for indoor forums, rallies, demonstrations, or similar activities. The revised policy permits such activities inside certain University facilities (excluding University residence halls and apartments, Greenwood Laboratory School, and the University’s entertainment and athletic facilities) to the extent that such activities: i) are silent demonstrations (e.g., “sit-ins”); ii) do not interfere with the reasonable operations of the specific indoor space; iii) comply with campus instruction; iv) do not extend beyond the business hours of the university’s indoor space; or iv) do not otherwise violate any policy of the University, including the Expressive Activity Policy.
Expressive Activity Policy

G5.02 Expressive Activity Policy

Missouri State University is committed to providing an environment where issues can be openly discussed and explored. The freedom to exchange views is essential to the mission of the University. This policy is in place to provide a community environment in which open discussion can occur without disrupting the academic mission or daily University functions, subject to constitutional time, place, and manner limitations and without unconstitutionally interfering with the rights of others.

All individuals may exercise the right of assembly, free speech, and expression throughout the outdoor areas of campus, when doing so does not disrupt the academic mission or daily University functions, and is consistent with University policy regarding time, place, and manner limitations. Expressive activities will not be limited to any specific outdoor areas on the University campus. However, the right of assembly and expression does not include unlawful activity that endangers the safety of the campus community or that destroys University property. Expressive activities are not to unduly disrupt traffic, either vehicular or pedestrian, or violate other time, place, and manner parameters specified in this policy. Forums, rallies, demonstrations, and other similar expressive activities are also not to occur within academic or other University buildings including University residence halls and apartments, or Greenwood Laboratory School. Expressive activities are not to unduly disrupt traffic, either vehicular or pedestrian or violate other time, place and manner parameters specified in this policy.

The following three locations on campus are most appropriate for outdoor forums, rallies, demonstrations, and other similar activities:

- The Bear Paw, located in the North Mall
- Trottier Plaza, located at the northwest entrance to Robert W. Plaster Stadium
- Strong Hall Amphitheater, located outside the east entrance to Strong Hall

Individuals are not restricted to these outdoor locations for expressive activities. Priority to use these the aforementioned locations will be as follows:

- Members of the University community with a reservation
- Other individuals or groups with a reservation
- Members of the University community without a reservation on a first come, first serve basis
- Other individuals or groups without a reservation on a first come, first serve basis

Any member of the University community may reserve one of these locations through the Event and Meeting Services Office (417-836-5653). All other individuals or groups may reserve one of these locations by registering with the Office of Safety and Transportation (417-836-5509). The University encourages everyone to coordinate with the Office of Safety and Transportation before conducting expressive activity on campus so appropriate arrangements can be made.
Amplification shall be limited to activities held at the Bear Paw and will be permitted only for individuals or groups who have reserved the Bear Paw. Amplification levels must not unreasonably interfere with the University’s daily operations, and shall not be permitted during the University’s midterm or final examination periods.

Time, place and manner parameters

This policy will be construed and applied on a content neutral basis. The following is a list of parameters for the time, place, and manner of activities that apply to all expressive activities on campus:

- The activity may not violate local ordinances or state or federal laws.
- The activity may not unduly disrupt traffic, either vehicular or pedestrian, or interfere with the ingress or egress to or from any building.

- The activity may not create unreasonable safety risks.
- Participants in the activity must not carry or bring to the activity the following items: weapons of any kind (including but not limited to those defined in Missouri Revised Statute § 571.010), ammunition, explosives, body armor, helmets, mace/pepper spray, masks, vehicles (including but not limited to motorcycles, automobiles, all-terrain vehicles, golf carts and bicycles), torches, and any other item identified by the University as increasing the risk of injury to event attendees and the campus community, including without limitation, any item identified in Op1.01-1 University Rules for Speakers and Facilities Usage.
- The activity may not deface or destroy, or create an unreasonable risk of defacing or destroying, University or other property.
- Noise levels should not interfere with classes, meetings, campus events, or operations and activities on campus. Amplification equipment shall be limited to activity held at the Bear Paw with a reservation. Moreover, amplification shall not be permitted during the University’s midterm and final examination periods.
- No event may exceed 8-4 hours in length in a 24 hour period.
- The location will be left in its original condition at the conclusion of the event, and reasonable charges or deposits may be imposed to enforce this requirement.

- Expression that is obscene, defamatory, or consists of fighting words, threats of physical harm, incites imminent lawless action, or is otherwise not entitled to protection as expression is not permitted.

Generally, indoor University spaces are not appropriate for forums, rallies, demonstrations, or similar activities; however, such activities may be permitted inside University facilities (excluding University residence halls and apartments, Greenwood Laboratory School, and University’s entertainment and athletic facilities) to the extent that such activities:
Schedule 1 – G5.02 Expressive Activity Policy

- Are silent demonstrations (e.g., “sit-ins”)
- Do not interfere with the reasonable operations of the specific indoor space
- Comply with campus instruction
- Do not extend beyond the business hours of the university’s indoor space, or
- Do not otherwise violate any policy of the University, including this Expressive Activity Policy.

Objections to expressive activities

The University recognizes that individuals or groups may be opposed to certain expressive activities or speakers. Disagreement with different opinions is acceptable; however, use of violence or violation of law or University policy is counter to creating an environment where issues can be openly discussed. An individual or group wishing to protest an event is subject to the same standards as the presenters. Individuals who choose to listen bear the responsibility of recognizing and honoring the right of free speech.

Response to violations

Violations of this policy may result in removal from campus, police arrest, and/or criminal charges. Members of the University community are subject to judicial review and disciplinary sanctions. Students will be subject to procedures established in the Code of Student Rights and Responsibilities. Faculty and staff disciplinary procedures will be processed according to guidelines established in the Faculty Handbook and the Employee Handbook. Any police arrest and criminal charges of students, faculty, or staff are separate from University judicial review or disciplinary sanction.

Related policies

All commercial expressive activities will be subject to the restrictions found in this policy and the restrictions found in the Advertising, Distribution, Solicitation and Facilities Usage Policy.

Line of authority

Responsible administrator and office: President

Contact person in that office: Chief of Staff and Assistant to the President for Governmental Relations

Effective date

Approved by Board of Governors: February 5, 2016 TBD
IV.A.

**RECOMMENDED ACTION** – Approval of Lease Agreement for the Lease of Property at 212 Harlin Drive, West Plains, Missouri.

The following resolution was moved by ___________________ and seconded by ___________________

**BE IT RESOLVED** by the Board of Governors for Missouri State University that the University enter into a Lease Agreement for the lease of certain real estate located at 212 Harlin Drive, West Plains, Missouri, for the amount of One Thousand Five Hundred Dollars ($1,500.00) per month, further described below:

The N ½ of Lots 5, 6, and 8 and all of Lot 7 in block 1 of V.P. Renfrow’s Second Addition to the City of West Plains, Missouri. Also, a part of Lots 1 and 2 of Col. Monks Subdivision of the NE ¼ of the NE ¼ of Section 29, Township 24 North, Range 8 West, described as follows: Beginning at a point 15 feet south and 15 feet east of the northwest corner of said NE ¼ of NE ¼, the same being the northwest corner of said Lot 1 of Col. Monks Subdivision, thence south 186.96 feet, thence east 205 ½ feet, thence north 7 degrees east to the north line of said Lot 2 of Col. Monks Subdivision, thence west along the south line of the Old Pottersville Road 232 feet to the point of beginning.

**BE IT FURTHER RESOLVED** that it is the determination of the Board of Governors that future lease agreements of certain real estate located at 212 Harlin Drive, West Plains, Missouri may be negotiated and entered into by the Chancellor of Missouri State University – West Plains in consultation with the President and Legal Counsel of Missouri State University with subsequent notification provided to the Board of Governors; and

**BE IT FURTHER RESOLVED** that the administration of the University, including the Chancellor and/or Director of Business and Support Services at the West Plains Campus, be authorized to prepare and execute appropriate legal documentation and perform other acts as may be necessary to implement this resolution.

VOTE:  AYE _______

NAY ______

COMMENTS:

The Richards House has been unoccupied for approximately two years. Lease of this facility will generate income to offset the costs associated with maintenance of the property.

This lease of property is a revenue generating agreement for the institution.

It is recommended that this resolution be approved.
This LEASE AGREEMENT made and entered into this _____ day of ___________ 2017, between THE BOARD OF GOVERNORS OF MISSOURI STATE UNIVERSITY – WEST PLAINS, hereinafter referred to as "Lessor," and MARY HASS SHEID, hereinafter referred to as "Lessee."

WITNESSETH:

1) Now, therefore, Lessor does hereby lease and demise unto Lessee, and Lessee does hereby take and hire from Lessor, the following described real estate located at 212 Harlin Drive in the city of West Plains in Howell County, Missouri, to-wit, hereinafter referred to as the "Premises":

   The N ½ of Lots 5, 6, and 8 and all of Lot 7 in block 1 of V.P. Renfrow’s Second Addition to the City of West Plains, Missouri. Also, a part of Lots 1 and 2 of Col. Monks Subdivision of the NE ¼ of the NE ¼ of Section 29, Township 24 North, Range 8 West, described as follows: Beginning at a point 15 feet south and 15 feet east of the northwest corner of said NE ¼ of NE ¼, the same being the northwest corner of said Lot 1 of Col. Monks Subdivision, thence south 186.96 feet, thence east 205 ½ feet, thence north 7 degrees east to the north line of said Lot 2 of Col. Monks Subdivision, thence west along the south line of the Old Pottersville Road 232 feet to the point of beginning.

2) The term of this Lease shall be for a period of six (6) months, possession to begin October 1, 2017, and expiring at midnight on March 31, 2018. Extensions, if any, will be negotiated by the Lessor and Lessee.

3) Lessee shall pay One Thousand Five Hundred Dollars ($1,500.00) per month payable by the 10th day of the month commencing on October 1, 2017. No security deposit will be required.

4) At any time during the term of this Lease, the Lessee may terminate this Lease provided Lessee has given Lessor ninety (90) days prior written notice of its intent to vacate the premises and said Lease shall terminate upon or after the expiration of said ninety (90) day period, as specified by notice, with no further rental due from Lessee to Lessor. If Lessee terminates the Lease under this paragraph, Lessee shall pay to the Lessor a sum equal to two (2) months’ base rent as a termination charge by the effective date of the termination.

5) In the event Lessor desires to sell the property during the term of this lease, Lessor agrees to give Lessee a notice in writing of at least 90 days before placing the property on the market. Lessee shall have a right to purchase said property at fair market value and shall have the right of first refusal before Lessor enters into an agreement for the sale of the property.

6) Lessor covenants and agrees as follows:
   a) Lessor is the owner of said property and has good right to lease the same and will warrant and defend the leasehold interest hereby created.
   b) Lessor shall deliver the premises to Lessee in a safe, clean, dry and habitable condition and in good order and repair, including electrical, plumbing, and all other facilities serving the premises.
   c) Lessee may peacefully and quietly hold and enjoy the Premises during the term hereof without any interruption from the Lessor or any other persons claiming under Lessor, subject, however, to the right of Lessor to inspect the Premises at reasonable times and intervals, upon reasonable notice to Lessee.
   d) Lessor shall maintain the HVAC, electrical, plumbing, roof and exterior of the Demised Premises and maintain the exterior property. Lessor shall maintain the lawn and associated plantings. Lessor agrees to maintain the premises so that the building is dry and habitable at all times.
   e) Lessor agrees to pay for all utility services for the demised premises during the term of this Lease.

Lessor
f) Lessor shall, at its expense, before commencement of the term of this Lease, have the air conditioning, heating, electrical, and plumbing equipment ("equipment") serving the premises inspected and placed in good operating condition. Upon Lessor’s failure to do so, Lessee may, at its option, cause equipment placed in good operating condition and deduct the reasonable expense thereof from the rent. The equipment will be maintained by Lessor at its expense. Should replacement of equipment become necessary through ordinary wear and tear or otherwise, Lessor, at its expense, agrees to replace same with another or others of at least equal efficiency and capacity to present equipment.

g) Lessor represents that it is protected by the State Legal Expense Fund, 105.711 RS Mo et seq. Lessor agrees to assume responsibility for their own acts during the performance of this Agreement and will not be responsible for the acts of Lessee.

h) Lessor covenants and agrees that at its own expense, and without any right of reimbursement from Lessee, it shall effect such improvements, alterations, repairs, additions or replacements to the Exterior Areas to fully and timely comply with the requirements of all governmental authorities applicable to the Exterior Areas, including, without limitation, planning and zoning rules and regulations, building, health and fire codes, the "American with Disabilities Act" of 1990 as amended and the Federal regulations promulgated thereunder (the "Disabilities Act"); provided, however, that with respect to the Disabilities Act, the parties agree as follows:
   (i) Each party shall have responsibility under the Disabilities Act for its own standards, criteria, policies, practices, and procedures.
   (ii) Lessee shall have the responsibility for the provision of “auxiliary aids and services” (as such term is used in the Disabilities Act) to its customers, if and to the extent required in connection with its operation of its business on the Premises.
   (iii) Unless specifically provided to the contrary elsewhere in this Lease, Lessor shall have responsibility for the removal of barriers in the Common Areas, where such removal is required by the Disabilities Act.
   (iv) Where barrier removal is not required by the Disabilities Act, but the use of alternative methods of providing access is required, Lessor or Lessee, as required in this Section, shall have responsibility for the use of such methods except to the extent that the Disabilities Act required alternative methods that involve services by University's/Grantee's employees for the retrieval or delivery of University's/Grantee's inventory.

7) Lessee covenants and agrees as follows:
   a) To pay the rent herein provided to Lessor within the time provided at such places and addresses as Lessor may reasonably designate in writing.
   b) The Lessee, during the term of this lease, may renovate, remodel, recondition, rehabilitate, convert, change, and alter the Interior of the Premises, and attach fixtures thereto, and make any and all improvements thereto, at the expense of the Lessee, and Lessee shall have full power and right, at any time during the term of this lease, provided Lessee is not then in default in the performance of any of its obligations hereunder, to tear down, remove any fixture on the leased Premises or any part thereof, or to alter or change the same in material respects, at the Lessee's expense; provided, however, that these rights may be exercised only in accordance with plans and specifications submitted to and approved in writing by the Lessor. The Lessee may make such reasonable variations from, and modifications in, such plans and specifications originally approved by the Lessor as the Lessee deems necessary in the course of carrying out such plans and specifications. All such renovating, remodeling, reconditioning, rehabilitating, converting, changing, and altering of the Premises, and all additions, structures, and fixtures added to the Premises, by the Lessee, which are remaining thereon at the termination of this lease, however, accomplished, or when the Lessee begins reconversion of the Premises, shall then become the property of the Lessor; and the Lessee shall be under no obligation to restore or reconvert the Premises to their condition at the time of the execution of this lease; provided, however, that in the event the Lessee determines to terminate this lease, except where such termination is in pursuance of an election made by the Lessee under the provisions of paragraph 4 hereof, and the conversion of the Premises has been actually commenced but has not been completed, the Lessee, at its sole option, before such termination becomes effective, shall either complete the
conversion or restore or reconvert the Premises to their condition at the time of the execution of
this lease; and, provided further, that in the event this lease has been terminated, except where
such termination is effected under the provisions of paragraph 5 hereof, the Lessee shall restore
or reconvert the Premises whenever the changes and alterations therein have been of a
temporary nature and have been designated as such in the plans and specifications approved
by the Lessor.

c) Lessee agrees to allow Lessor access to the demised premises for the purpose of conducting
the following events. Lessor will be responsible for all costs, coordination, setup, take down, and
cleanup for the events.

i) Missouri State University Board of Governors reception held the evening before the board
   of governors meeting that is held on the West Plains campus (date TBD).

ii) Student Leaders and Honors Program Students Ice Cream Social held at the beginning of
    the fall semester (date TBD).

iii) Chancellor’s Holiday Reception held during the first part of December (date TBD).

d) Lessee shall maintain during the term of this Lease standard Lessee’s insurance for the full value
   of the Lessee-owned contents of the facility.

8) Lessee shall have no right to assign this Lease or sublet the Demised Premises without the prior
   written consent of Lessor.

9) In the event that it shall become necessary for Lessor or Lessee to institute legal action as a result
   of the default by the other party under any terms of this Lease Agreement, the prevailing party shall
   be entitled to court and legal fees, including a reasonable attorney’s fee.

10) Any notices authorized or required to be given hereunder may be personally delivered (with delivery
    to one Lessor or Lessee sufficient as delivery to all), or by depositing the same in the United States
    Mail, postage prepaid, Certified Mail, Return Receipt Requested, and if intended for Lessor,
    addressed as follows: Missouri State University – West Plains, Attention, Scott Schneider, 128
    Garfield Avenue, West Plains, MO 65775; and if addressed to Lessee, addressed as follows: Mary
    Sheid, 212 Harlin Drive, West Plains, MO 65775. Properly addressed and mailed, delivery shall be
deemed upon mailing.

11) This Lease Agreement may be modified or extended only as set out herein.

12) This Lease shall be binding upon the parties hereto, their successors, personal representatives, heirs
    and assigns.

IN WITNESS WHEREOF, the parties, by their duly authorized representatives, have hereunto set
their hands the day and year first above written.

BOARD OF GOVERNORS OF MISSOURI STATE UNIVERSITY –
WEST PLAINS, LESSOR

By: _____________________________________________ Date

MARY HASS SHEID, LESSEE

By: _____________________________________________ Date
ACKNOWLEDGMENTS

STATE OF MISSOURI )
COUNTY OF HOWELL )

On this _____ day of ___________, 2017, before me personally appeared ____________________________, to me personally known, who being duly sworn, did say that he/she is ________________________________, of ____________________________, and that the said instrument was signed and sealed in behalf of said corporation by authority of its Board of Directors and the said President acknowledged said instrument to be the free act and deed of said Board of Governors.

In Testimony Whereof, I have hereunto set my hand and affixed my official seal the day and year first above written.

___________________________
Notary Public

My Commission expires: ____________

STATE OF MISSOURI )
COUNTY OF __________ )

On this ____________________ day of __________, 2017, before me personally appeared ____________________________, to me personally known, who being duly sworn, did say that he/she is ____________________________, for Missouri State University and that the said instrument was signed and sealed in behalf of the Board of Governors of Missouri State University and acknowledged to me that he/she executed the same for the purposes therein stated, and by authority of the Board of Governors of Missouri State University.

In Testimony Whereof, I have hereunto set my hand and affixed my official seal the day and year first above written.

___________________________
Notary Public

My Commission expires: ____________

Lessor
V.A.

RECOMMENDED ACTION - Approval of Procurement Activity Report

The following resolution was moved by ________________________________
and seconded by ________________________________.

BE IT RESOLVED by the Board of Governors for Missouri State University
that the attached Activity Report presented by the Procurement Services Office be
approved.

VOTE: AYE _______

NAY _______

COMMENTS:

This report summarizes Procurement Services Office activities from August 11, 2017
through September 14, 2017.
Property Lease

Lease of Classroom Space  $1,361.25
Theatre and Dance (Estimated)

Recommend approval to enter into a classroom lease for the fall 2017 semester for a required course for Theatre and Dance students. Campus space is not available during the time the course needs to be offered in order to not conflict with other required classes.

The term of the lease is from August 21, 2017 through December 14, 2017, and one lump-sum payment of $1,361.25 is to be made for the full semester.

Subject to need and continued satisfactory service, any lease extensions will be made on a monthly or semester basis.

A purchase order will be issued to the Messiah Project, Incorporated, for the first-floor studio in the brick building located at 931 South Kickapoo Avenue, Springfield, Missouri.

Note: Funding to be from ongoing operational budgets.

Contract for the purchase of goods and services estimated > $100,000 that was competitively bid.

Software for Online Admission Application/CRM  $273,141.00
Office of Admissions (Estimated Three-Years)

Recommend approval to enter into an agreement with Hobsons for an undergraduate Online Admission Application and Customer Relationship Management (CRM) platform.

A quality online admission application and CRM platform is a key resource to enhance the University’s search, recruitment, enrollment and retention.
Major benefits of a new Online Admission Application/CRM include:

- Customizable and mobile optimized online application
- Ability to create multiple applications across units
- Web-based applicant portal and dynamic admission checklist
- Streamlined application process with the ability to collect digital documents
- Remote access to applicant data via web-based administrative portal
- Ability to customize and target communication via the CRM platform
- Opportunity to manage University events
- Customized communications to encourage campus tours, visits and event registrations
- Two-way text messaging with integration to the CRM platform

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<td>$273,141.00</td>
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Three optional two-year renewals are available that cap annual increases to three percent (3%). **Subject to continued need and ongoing satisfactory performance, future renewal options will be exercised when applicable.**

**Note:** Funding for the first year to be from the Office of Student Affairs, and ongoing costs to be from the President’s Enhancement Fund.

**Single purchase > $100,000 from established cooperative contract**

- **Furniture** $295,000.00
- **Health and Wellness Center** (Estimated)

Pursuant to University policy, which allows for participation in contract agreements established by other public entities, recommend the purchase of Steelcase furniture for the Health and Wellness Center.

Educational and Institutional (E & I) Cooperative Services Contract CNR-01146 for Steelcase Furniture was utilized, through Color Art Integrated Interiors, LLC.
Note: Funding to be from the net assets of the Health and Wellness Center.

Single purchase > $100,000 from established cooperative contract

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<tr>
<th>Furniture</th>
<th>$363,060.95</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meyer Library</td>
<td>(Estimated)</td>
</tr>
</tbody>
</table>

Pursuant to University policy, which allows for participation in contract agreements established by other public entities, recommend the purchase of Steelcase furniture for Meyer Library.

Educational Institutional (E & I) Cooperative Services Contract CNR-01146 for Steelcase Furniture was utilized, through Color Art Integrated Interiors, LLC.

Note: Funding to be from one-time carryforward funds of the Meyer Library.
VI.A.

RECOMMENDED ACTION – Approval of an Intergovernmental Agreement Regarding Law Enforcement Services with Missouri State University for Fiscal Year 2018.

The following resolution was moved by __________________________and seconded by __________________________.

BE IT RESOLVED by the Board of Governors for Missouri State University that the University continue the Intergovernmental Agreement for Law Enforcement Services for Fiscal Year 2018 with the City of Springfield at a cost of $722,219.28; and

BE IT FURTHER RESOLVED that the Intergovernmental Agreement will be effective from July 1, 2017 through June 30, 2018, and will continue on a month-to-month basis as needed; and

NOW, THEREFORE, BE IT RESOLVED by the Board of Governors for Missouri State University that the proposed Intergovernmental Agreement Regarding Law Enforcement Services be approved and that the President of the University be authorized to sign said Agreement on behalf of the Board of Governors.

VOTE: AYE____

NAY____

COMMENTS:

The agreement with the City of Springfield provides for law enforcement services associated with the Springfield Police Department and the Missouri State University Springfield Police Substation. This annual contract represents a .32% increase from Fiscal Year 2017. This increase of $2,293.82 is due to a slight increase in service costs to include salaries and benefits for ten officers.

The annual contract will be distributed between Missouri State University budget accounts as indicated below:

<table>
<thead>
<tr>
<th>Total Cost</th>
<th>E&amp;G</th>
<th>Residence Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>$722,219.28</td>
<td>$541,664.46</td>
<td>$180,554.82</td>
</tr>
</tbody>
</table>

The University General Counsel has reviewed the agreement for legal sufficiency.
INTERGOVERNMENTAL AGREEMENT REGARDING LAW ENFORCEMENT SERVICES

THIS AGREEMENT, made and entered into this __________ day of __________, 2017, by the parties identified above.

WHEREAS, the City of Springfield, Missouri ("City"), a municipal corporation organized and operating under the Constitution and Laws of the State of Missouri and the Springfield City Charter, and the Board of Governors ("Board") of Missouri State University, a university organized and operating under the Constitution and Laws of the State of Missouri, are mutually desirous of revising, renewing, and extending the period of the preexisting intergovernmental agreement for providing police services within and around the immediate campus area of Missouri State University ("MSU"); and

WHEREAS, the City and the Board are resolved that an agreement providing for enhanced law enforcement services within and around the campus of Missouri State University will be of mutual benefit to the parties to this agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE TERMS AND CONDITIONS HEREBIN STATED, THE CITY AND THE BOARD HEREBY ENTER INTO THE FOLLOWING AGREEMENT REGARDING LAW ENFORCEMENT SERVICES TO BE PROVIDED WITHIN AND AROUND THE CAMPUS OF MISSOURI STATE UNIVERSITY:

A. STAFFING OF THE POLICE SUBSTATION

1. The Board agrees to provide, at its expense, a facility deemed suitable by the City for a police substation, to be located on the MSU campus as defined in Section B.1. of this agreement.

2. The City agrees to staff the police substation located on the MSU campus as promised herein. The Springfield Police Department expressly reserves and retains the right to direct and supervise all police personnel assigned to the police substation at all times this agreement is in effect. If requested, the Board agrees to provide approximately 60 hours per week of clerical assistance for the substation operation. The City will provide personnel and equipment for the purpose of staffing the police substation in accordance with the following schedule:

   a. The City agrees to staff the MSU substation with ten (10) full-time police officers. The minimum staffing of the MSU substation shall not fall below eight (8) full-time police officers, unless officers are reassigned pursuant to Section B, Paragraph 5 below. Those ten (10) police officers shall consist of: eight (8) police officers, one (1) police sergeant, and one (1) police corporal. In the event that the staffing is reduced to eight (8) full-time police officers, the officers shall consist of: seven (7) police officers, one (1) police sergeant or acting sergeant. It is the intention of the City to provide 24-hour a day police services to the campus community.

   b. The division of costs for the ten (10) police officers provided to MSU under the terms of this agreement shall be that MSU fund 80% and the City fund 20% of the combined total of the salaries of the ten full-time officers assigned to the substation. The term "salaries" as used in this paragraph shall include: the officers' base salary and benefits.
Should the parties agree in writing to increase the staffing of the substation to more than ten (10) officers, MSU shall be responsible for the entire salary of any additional officer assigned to the substation. If the staffing shall fall below ten (10) police officers pursuant to Paragraph 5 below for a period in excess of fourteen (14) days, MSU shall only be responsible for 80% of the total salaries of the remaining officers. (See Exhibit B attached hereto and incorporated herein by reference.)

c. Officers of the MSU substation who participate in special safety and enforcement projects agreed to between MSU safety and security staff and the Police MSU Substation Supervisor within and around the campus of MSU will be compensated at the guaranteed rate of time and one-half (money or compensatory time) for the actual time during which the officer is engaged in the performance of the special project. The cost of such compensation shall be reimbursed by the Board. Assignment of officers to such MSU special safety or enforcement projects is at the discretion of the Police MSU Substation Supervisor.

d. **FISCAL YEARS SUBSEQUENT TO FY 13-14**

(1) The parties may reassess the staffing needs for the police substation on an annual basis, or more frequently if either party deems it necessary to do so.

(2) The parties agree that the staffing levels designated in paragraph A.2.a will be continued for so long as this agreement is in effect, provided the staffing levels are not adjusted or revised in accordance with the terms and conditions of this agreement.

B. **LAW ENFORCEMENT SERVICES TO BE PROVIDED BY THE CITY**

1. The parties agree and understand that the primary purpose of the police substation is to bring the police and the campus community together in a unified effort to: (1) enhance public safety, (2) prevent crime, and (3) to make this, as a neighborhood, a better place to live. The parties therefore commit to exercise their best efforts to cooperate and communicate regarding matters of obvious concern. Recognizing the University may have helpful information, both parties are committed to open communication and, as appropriate, exchange of information. Nothing in this paragraph should be construed to require the divulgence of confidential or privileged information. The objective will be to create positive interaction and to establish a partnership between police and the campus community as defined in this section in the process of problem identification and problem resolution. MSU authorizes City of Springfield to enforce City of Springfield ordinances as well as state law on the campus.

a. The MSU campus is identified and delineated in the map, Exhibit A, attached and incorporated herein by reference. The MSU main campus is generally described as that area bounded by National Avenue on the east; Loren Street on the south; Kimbrough Street on the west; and Walnut Street on the north (including Kentwood Hall properties between Walnut and St. Louis). In addition, it is agreed that SPD officers assigned to the MSU Police Substation will routinely patrol and provide police services to all other satellite facilities owned or leased by MSU within two miles of the boundaries of the campus area as herein defined.

b. In addition to the defined area just described, the term "in and around the MSU campus area" shall include the perimeter streets, and shall also include all recognized Greek fraternity and sorority houses, without regard to their location, whether inside or outside the defined area.

2. Springfield police officers assigned to the police substation will work flexible shifts in accordance with the calls for service and crime-problem identification demands, based upon a 40 hour work week for each officer assigned.

3. The Springfield Police Department will assign an extra officer to the substation when requested, on designated Friday and Saturday nights, such as at the beginning and end of the school year, as determined by the substation supervisor.

4. Springfield police officers assigned to the police substation will provide a visible police presence to the MSU campus area.

5. The parties expressly agree and stipulate that, notwithstanding any other provision of this agreement to the contrary, the Springfield Police Department reserves and retains the right to temporarily reassign police officers assigned to the police substation to other duties in the following situations:

a. Emergency situations. In cases of emergency, or extraordinary needs for service in other locations the Springfield
Police Department reserves and retains the right to utilize those officers assigned to the MSU substation as needed, for the duration of the emergency, including below the minimum staffing noted in Section A.2.A, if needed.

b. Temporary reassignment. Temporary reassignment shall mean reassignment of any of the ten (10) police officer positions to another location other than the MSU substation on a full-time basis. In the event of reassignment, the City expressly agrees to restore the staffing of the police substation to the levels set out in Section A of this agreement as soon as possible in light of existing circumstances. Any temporary reassignment will adhere to the minimum staffing levels agreed to in Section A.2.A.

6. The parties agree and understand that police officers assigned to the police substation will on occasion be absent from their duties as a result of illness, vacation leave, personal leave, funeral leave, compensatory time, training time, court appearances, military leave, and other similar causes of absence. In such cases the existing workload will be assumed by other members of the police substation staff. In the event an absence of any officer assigned to the police substation exceeds fourteen (14) days, the City will review the staffing needs of the police substation and will assign such additional personnel as may be necessary to the effective functioning of the unit depending upon availability of personnel.

7. The parties agree and understand that assignment to the MSU Substation will not penalize assigned employees and will not in any way threaten employment rights, promotional opportunities, training opportunities, or fringe benefits.

8. The Chief of the Springfield Police Department and the MSU President, or their designees, shall be responsible for developing all necessary procedures for the coordination of services between the two agencies.

9. The substation will maintain records which are available to the President (or his designee) to include but not limited to:

   a. Substation payroll records.
   b. Time sheet and detailed billing information sufficient for invoice reconciliation.
   c. Work schedule of substation officers.
   d. Calls For Service data within the designated substation area as defined by this contract.
   e. Appropriate crime statistic information sufficient for Federal CLERY reporting.
   f. Provide information consistent with legal restrictions from police reports.
   g. Equipment purchase orders.
   h. Data by city service center.

C. RESPONSIBILITIES OF THE BOARD OF GOVERNORS

1. The Board agrees to provide and maintain a facility mutually deemed suitable by the City and the Board for a police substation, to be located in the MSU campus area as defined in Section B.1. of this agreement. The Board agrees to bear sole responsibility for the cost of operating and maintaining such facility for so long as this agreement is in effect.

2. The Board agrees to pay for services provided by the City in a total amount not to exceed Seven Hundred Twenty-Two Thousand, Two Hundred Nineteen Dollars and Twenty-Eight Cents ($722,219.28) based on the cost projections set forth in Exhibit B and C attached hereto and incorporated herein by reference.

3. The Board agrees to pay the cost of the overtime, uniform allowance, equipment depreciation, transportation, software and training costs of all full-time officers assigned to the substation based on the cost projections set forth in the attached Exhibits B and C, attached hereto and incorporated herein by reference.

4. The City will bill the Board on a monthly basis for law enforcement services provided pursuant to this agreement. The Board shall remit to the city, money owed to the City under the terms of this agreement, on or before thirty (30) days after the date of the invoice, unless there is a dispute regarding the amount of the invoice in which case the parties agree to meet and discuss in good faith the invoice amount.

D. OTHER TERMS AND CONDITIONS
1. **Conflicts.** No salaried officer or employee of the City, and no member of the City Council or the Board shall have a financial interest, direct or indirect, in this contract. A violation of this provision renders the contract void.

2. **Liability.** The City hereby agrees to assume responsibility for the liabilities imposed by law on its employees, agencies, and institutions, including but not limited to all actions of its police officers undertaken on the MSU campus. The Board hereby agrees to assume responsibility for the liabilities imposed by law on its employees, agencies, and institutions. Nothing herein shall be construed to waive any sovereign, official or governmental immunity applicable to either party, its board or council members, officers or employees.

3. **Notices.** All notices required or permitted herein under and required to be in writing may be given by first class mail addressed to the Springfield City Manager, 840 Boonville, Springfield, Missouri 65802, and to the Board of Governors, Missouri State University, 901 South National, Springfield, Missouri 65807. The date of delivery of any notice shall be the date falling on the second full day after the date of its mailing.

4. **Jurisdiction.** This agreement and every question arising thereunder shall be construed and determined according to the laws of the State of Missouri. Should any part of this agreement be adjudicated, venue shall be proper only in the Circuit Court of Greene County, Missouri.

5. **Termination of Agreement.** Either party shall have the right to terminate this agreement upon giving written notice of intent to terminate to the other party at least 180 days prior to the date of termination.

6. **Failure of Appropriations and Cancellation of Agreement.** The parties mutually agree and understand that continuation of this agreement is subject to annual budget appropriations. Subject to the requirements of Section D.5., should the Springfield City Council or the Board fail to appropriate funds to continue staffing of the police substation, this agreement may be terminated by either party as of the last date upon which appropriated funds are available to either or both parties for continuation of staffing under the agreement.

7. **Nondiscrimination.** The parties agree not to discriminate on the basis of age, sex, religion, disability, race, national origin, ancestry, veteran status, sexual orientation, gender identity, or color, in employment, accommodation or provision of services in carrying out the terms and provisions of this agreement.

8. **Term of the Agreement.** Subject to all of the foregoing terms and conditions, the term of this Agreement shall be from July 1, 2017 through June 30, 2018. Thereafter, the parties may annually renew the Agreement for successive periods under such terms and conditions as may be agreed to at that time. Each addendum or renewal of the Agreement shall be in written form, executed by the Springfield City Manager and the President for MSU, on such terms and conditions as may be agreed to by the City Manager and the President for MSU. Should the term of this contract end without a renewal being timely enacted, parties shall continue to follow these contract terms on a month-to-month basis until such time a new contract can be executed or one of the parties terminates the contract pursuant to Paragraph D.5 above.

9. **Compliance with all laws.** The parties agree to abide and follow all federal, state, and local laws in performing the duties set forth in this contract including, without limitation, Mo. Rev. Stat § 173.2050, which requires the parties to establish and follow certain policies and protocols regarding sexual assault, domestic violence, dating violence, and stalking involving Students and other members of MSU's campus community. Said policies and protocols are shown in Exhibit D, which is attached hereto and incorporated herein by reference.
IN WITNESS WHEREOF, the parties hereto have set their hands and seals on the day and year herein stated.

APPROVED AS TO FORM

By: ________________________________
Attorney for Board of Governors

APPROVED AS TO FORM

By: ____________________________
City Attorney or Assistant

The Board of Governors of Missouri State University

By: ________________________________
President of the University

The City of Springfield, Missouri

By: ________________________________
City Manager, Deputy or Assistant City Manager

CERTIFICATE OF DIRECTOR OF FINANCE

I certify that the expenditure contemplated by this document is within the purpose of the appropriation to which it is to be charged and that there is an unencumbered balance of appropriated and available funds to pay therefor.

______________________________
Director of Finance or his designee
EXHIBIT A
MSU CAMPUS MAP
EXHIBIT B
Cost of MSU Substation Account
FY 17-18

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>SALARIES / BENEFITS*</td>
<td></td>
</tr>
<tr>
<td>Sergeant (1), Corporal (1), and Officers (8)</td>
<td></td>
</tr>
<tr>
<td>MSU Cost – 80% of Total Cost</td>
<td>$628,672.42</td>
</tr>
<tr>
<td>OVERTIME</td>
<td>41,368.00</td>
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<tr>
<td><strong>Subtotal:</strong></td>
<td>$670,040.42</td>
</tr>
<tr>
<td>OVERHEAD:</td>
<td></td>
</tr>
<tr>
<td>UNIFORM ALLOWANCE (10 Officers)</td>
<td>$14,500.00</td>
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<tr>
<td>TRAINING COST</td>
<td>$4,400.00</td>
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<tr>
<td>TRANSPORTATION AND SOFTWARE COST **</td>
<td>$33,278.86</td>
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<tr>
<td><strong>Subtotal:</strong></td>
<td>$52,178.86</td>
</tr>
<tr>
<td><strong>Total Contract Amount</strong></td>
<td>$722,219.28</td>
</tr>
</tbody>
</table>

* Salary information is calculated at actual officer’s salaries and top step for vacant positions and includes longevity pay, education incentive, pension contribution, Medicare, workers’ comp, etc. Salaries and Benefits above is 80% of cost.

** (See Exhibit C)
**EXHIBIT C**

**MSU Substation Transportation and Software Cost**

**FY 17-18**

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2016</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crown Vic</strong></td>
<td>$37,426.00</td>
<td>$38,350.00</td>
<td>$38,274.00</td>
</tr>
<tr>
<td><strong>Ford Explorer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Purchase cost w/equipment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$84,289.69</td>
<td>$85,498.00</td>
<td>$85,999.00</td>
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<tr>
<td><strong>7 Year Depreciation</strong></td>
<td>$5,346.57</td>
<td>$5,478.57</td>
<td>$5,610.57</td>
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<tr>
<td><strong>Annual Depreciation for all three (3) vehicles</strong></td>
<td>$32,152.00</td>
<td>$32,691.00</td>
<td>$33,126.00</td>
</tr>
<tr>
<td>**Fuel Cost **</td>
<td>$3,463.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Maintenance and Repair Cost **</td>
<td>$4,335.55</td>
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<td></td>
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<tr>
<td><strong>Vehicle Subtotal</strong></td>
<td>$26,343.56</td>
<td>$22,751.50</td>
<td>$22,292.00</td>
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</tbody>
</table>

**Bicycles**

**Ten (10) Patrol Bicycles in Fleet**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Purchase Cost</strong></td>
<td>$2,116.60</td>
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<tr>
<td><strong>3 Year Depreciation</strong></td>
<td>$705.53</td>
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<tr>
<td><strong>Annual Depreciation for ten (10) bicycles</strong></td>
<td>$7,055.30</td>
</tr>
<tr>
<td><strong>Bicycle Subtotal</strong></td>
<td>$7,055.30</td>
</tr>
</tbody>
</table>

**Software**

**Ten (10) Office 365 annual software license fees**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Software Subtotal</strong></td>
<td>$1,989.00</td>
</tr>
<tr>
<td><strong>Total Annual Transportation and Software Cost</strong></td>
<td>$33,278.86</td>
</tr>
</tbody>
</table>

* Cost of the vehicle with standard law enforcement, including mobile data terminal and emergency equipment. All equipment will be maintained in good working order.

**Figure based on actual and averages for FY16 (July 2015-June 2016). Figures from Fleet Administrator.
EXHIBIT D

Policies and Protocols Regarding
Sexual Assault, Domestic Violence, Dating Violence, and Stalking

Consistent with the provisions of Title IX of the Education Amendments of 1972, 20 U.S.C.A. § 1681, et seq. ("Title IX"), and the Violence Against Women Act ("VAWA"), MSU will investigate all reports of sexual assault, domestic violence, dating violence and stalking that are brought to MSU’s attention, regardless as to where the conduct is alleged to occur, which involves member(s) of the MSU campus community. (Note: Such reports will be investigated by MSU regardless as to where the conduct is alleged to have occurred, in that MSU is obligated to determine whether the alleged conduct occurred in the context of an educational program or activity, or has continuing effects on the MSU campus or in an off-campus educational program or activity.)

Consistent with the requirements of Title IX and VAWA, and the directives of the Department of Education’s Office for Civil Rights ("OCR"), MSU will honor the wishes of a complainant/victim as to whether to notify the Springfield Police Department of an incident of alleged sexual assault, domestic violence, dating violence and or stalking. The reporting of any such offense will be the choice and the responsibility of the complainant/victim. Notwithstanding the foregoing, nothing in this Exhibit D shall be construed so as to preclude the Springfield Police Department from investigating any and all allegations of criminal activity – including allegations of sexual assault, domestic violence, dating violence, or stalking – that are reported to the Springfield Police Department or otherwise come to the attention of the Springfield Police Department.

Subject to its obligations under the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g; 34 CFR § 99 et seq. ("FERPA"), MSU will cooperate with the Springfield Police Department, in terms of any law enforcement investigation of sexual assault, domestic violence, dating violence and or stalking involving members of the MSU campus community, if authorized by the complainant/victim or pursuant to a lawfully issued search warrant, subpoena, or court order. The Springfield Police Department agrees to use best efforts to communicate with MSU regarding investigations or reports of sexual assault, domestic violence, dating violence and or stalking involving members of MSU’s campus community, provided that such communication, in the reasonable estimation of the Springfield Police Department or the Greene County Prosecuting Attorney, will not jeopardize the integrity of an investigation, or subsequent prosecution, of sexual assault, domestic violence, dating violence and or stalking.

Depending on the facts and circumstances of an individual case, one or both parties may have jurisdiction to investigation incident of sexual assault, domestic violence, dating violence and or stalking involving members of the MSU campus community. The term jurisdiction, as used herein, means that MSU shall have jurisdiction to conduct investigations consistent with its Title IX/VAWA obligations and its educational interests, whereas SPD shall have jurisdiction to conduct investigations from a law enforcement/criminal perspective. Both parties understand and agree that such investigations are independent and may happen simultaneously, and agree to provide one another with as much courtesy and communication as may be possible, given the facts and circumstances of the individual case.

The parties acknowledge and agree that this Exhibit D is intended fully conform to the requirements of Mo. Rev. Stats. § 173.2050. The parties further acknowledge that, pursuant to Mo. Rev. Stat. § 173.2050.3, the Missouri Department of Public Safety has been charged with promulgating rules and regulations by August 28, 2016, to facilitate the implementation of the requirements of Mo. Rev. Stat. § 173.2050. Thus, the parties agree to evaluate any and all such promulgating rules and regulations, and to work together in good faith to modify their collaborative practices and, as necessary, this Exhibit D, to ensure continued legal compliance.
VI.B.

RECOMMENDED ACTION – Approval of a Memorandum of Understanding Regarding Law Enforcement Services with Missouri State University for the Mountain Grove Campus.

The following resolution was moved by __________________________ and seconded by __________________________.

WHEREAS, Mo. Rev. Stat. § 173.2050 requires that the governing board of each Missouri public institution of higher education shall collaborate with the law enforcement agency that has jurisdiction over the premises of said institution for purposes of entering into a memorandum of understanding concerning instances of sexual assault, domestic violence, dating violence, and stalking involving the institution’s students;

WHEREAS, in order to ensure compliance with Mo. Rev. Stat. § 173.2050, Administration recommends approval of the proposed Memorandum of Understanding Regarding Law Enforcement Services between the City of Mountain Grove and Missouri State University for the Mountain Grove Campus (“MOU”); and

WHEREAS, in substance the proposed MOU is consistent with and agreement executed between the Springfield Police Department and the Springfield Campus.

NOW, THEREFORE, BE IT RESOLVED by the Board of Governors for Missouri State University that the proposed Memorandum of Understanding Regarding Law Enforcement Services be approved, and that the President of the University be authorized to sign said Memorandum of Understanding on behalf of the Board of Governors.

VOTE: AYE____

NAY____

COMMENTS:

The Memorandum of Understanding Regarding Law Enforcement Services between Missouri State University and the City of Mountain Grove (“MOU”) is being recommended in order to ensure compliance with legislation approved through Senate Bill 921 from the 2016 Missouri legislative session, which was subsequently codified at Mo. Rev. Stat. § 173.2050. The MOU outlines the policies and protocols whereby the Mountain Grove Campus and the Mountain Grove Police Department will collaborate regarding the investigation of and response to allegations of sexual assault, domestic violence, dating violence, and stalking that involve students.

The proposed MOU, in substance, is consistent with the agreement executed between the Springfield campus and the Springfield Police Department, and was drafted by the University’s General Counsel in order to ensure legal sufficiency.
MEMORANDUM OF UNDERSTANDING REGARDING LAW ENFORCEMENT SERVICES

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into this __________ day of __________, 2017 by and between the Board of Governors of Missouri State University ("Board") and the City of Mountain Grove, Missouri ("City").

WHEREAS, City is a municipal corporation organized and operating under the Constitution and Laws of the State of Missouri and the Mountain Grove Home Rule City Charter;

WHEREAS, Board is a public institution of higher education organized and operating under the Constitution and Laws of the State of Missouri and located in Mountain Grove, Missouri;

WHEREAS, the parties desire to enter into this MOU in order to establish their respective obligations relating to allegations, complaints, and/or incidents of sexual assault, domestic violence, dating violence, and stalking that occur on or adjacent to the Missouri State University ("MSU") Mountain Grove campus and/or which involve members of the MSU Mountain Grove campus community.

NOW, THEREFORE, MSU and the City agree to the following:

1. All law enforcement functions pertaining to allegations, complaints, and/or incidents of sexual assault, domestic violence, dating violence, and/or stalking, will be performed by the City’s police department (i.e., the Mountain Grove Police Department), inasmuch as the there is no commissioned campus police department on the MSU Mountain Grove campus. MSU will fully cooperate with the Mountain Grove Police Department in any response or investigation efforts to the extent permitted by applicable federal, state, and local law.

2. Consistent with the provisions of Title IX of the Education Amendments of 1972, 20 U.S.C.A. § 1681, et seq. ("Title IX"), and the Violence Against Women Act ("VAWA"), MSU will investigate all reports of sexual assault, domestic violence, dating violence and stalking that are brought to MSU’s attention, regardless as to where the conduct is alleged to occur, which involve member(s) of the MSU Mountain Grove campus community. (Note: Such reports will be investigated by MSU regardless as to where the conduct is alleged to have occurred, in that MSU is obligated to determine whether the alleged conduct occurred in the context of an educational program or activity, or has continuing effects on the MSU campus or in an off-campus educational program or activity.)

3. Consistent with the requirements of Title IX and VAWA, and the directives of the Department of Education’s Office for Civil Rights ("OCR"), MSU will honor the wishes of a complainant/victim as to whether to notify the Mountain Grove Police Department of an incident of alleged sexual assault, domestic violence, dating violence and/or stalking. The reporting of any such offense will be the choice and the responsibility of the complainant/victim. Notwithstanding the foregoing, nothing in this MOU shall be construed so as to preclude the
Mountain Grove Police Department from investigating any and all allegations of criminal activity – including allegations of sexual assault, domestic violence, dating violence, or stalking – that are reported to the Mountain Grove Police Department or otherwise come to the attention of the Mountain Grove Police Department.

4. Subject to its obligations under the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g; 34 CFR § 99 et seq. (“FERPA”), MSU will cooperate with the Mountain Grove Police Department, in terms of any law enforcement investigation of sexual assault, domestic violence, dating violence and/or stalking involving members of the MSU Mountain Grove campus community, if authorized by the complainant/victim or pursuant to a lawfully issued search warrant, subpoena, or court order. The Mountain Grove Police Department agrees to use best efforts to communicate with MSU regarding investigations or reports of sexual assault, domestic violence, dating violence and or stalking involving members of MSU’s Mountain Grove campus community, provided that such communication, in the reasonable estimation of the Mountain Grove Police Department or the Wright County Prosecuting Attorney, will not jeopardize the integrity of an investigation, or subsequent prosecution, of sexual assault, domestic violence, dating violence and/or stalking.

5. Depending on the facts and circumstances of an individual case, one or both parties may have jurisdiction to investigate an incident of sexual assault, domestic violence, dating violence and or stalking involving members of the MSU Mountain Grove campus community. The term jurisdiction, as used herein, means that MSU shall have jurisdiction to conduct investigations consistent with its Title IX/VAWA obligations and its educational interests, whereas the Mountain Grove Police Department shall have jurisdiction to conduct investigations from a law enforcement/criminal perspective. Both parties understand and agree that such investigations are independent and may happen simultaneously, and agree to provide one another with as much courtesy and communication as may be possible, given the facts and circumstances of the individual case.

6. The parties acknowledge and agree that this MOU is intended to fully conform to the requirements of Mo. Rev. Stat. § 173.2050. The parties further acknowledge that, pursuant to Mo. Rev. Stat. § 173.2050.3, the Missouri Department of Public Safety has been charged with promulgating rules and regulations by August 28, 2016, to facilitate the implementation of the requirements of Mo. Rev. Stat. § 173.2050. Thus, the parties agree to evaluate any and all such promulgating rules and regulations, and to work together in good faith to modify their collaborative practices and, as necessary, this MOU, to ensure continued legal compliance.

7. This MOU shall not be modified except upon the mutual consent and approval memorialized by formal written amendment.
IN WITNESS WHEREOF the parties have executed this Agreement as indicated by their signatures set forth below.

The Board of Governors of Missouri State University

________________________________________________________________________________

President
Missouri State University
Date

The City of Mountain Grove, Missouri

________________________________________________________________________________

City Official Name
Title
City of Mountain Grove, Missouri
Date
VI.C.

RECOMMENDED ACTION - Approval of consultant and authority to enter into agreements for professional services in conjunction with the Federal Communications Commission channel reassignments to television stations KOZK and KOZJ.

The following resolution was moved by __________________________ and seconded by __________________________:

BE IT RESOLVED by the Board of Governors of Missouri State University that the professional services of Marsand, Inc. in conjunction with the Federal Communications Commission channel reassignments to television stations KOZK and KOZJ be accepted, approved, and awarded.

BE IT FURTHER RESOLVED that Marsand, Inc. perform this work for a fixed fee of One Hundred One Thousand One Hundred Eighty-seven and 00/100ths dollars ($101,187.00) plus reimbursable expenses.

BE IT FURTHER RESOLVED that this be paid by the KOZK Fordland Reassign and KOZJ Joplin Reassign budgets funded from the Federal Communications Commission Reimbursement Fund.

BE IT FURTHER RESOLVED that the Vice President for Administrative Services or the University Architect and Director of Planning, Design & Construction be authorized to sign the agreement with the firm selected, incorporated herein by reference, and perform those acts necessary to carry out and perform the terms of the agreement.

VOTE: AYE _____

NAY _____

COMMENTS:

Following an engineering study by Marsand, Inc. on the KOZK and KOZJ television stations channel reassignment plan, the University would like to proceed with the Federal Communications Commission mandated channel reassignments to the television stations. The base fee includes programming and a survey of existing conditions to prepare measured drawings needed for the preparation of bid documents.

Two separate professional services agreements will be issued, one for the KOZK television station located in Fordland, MO and one for the KOZJ television station located in Joplin, MO.

Upon Federal Communications Commission approval, this project will be paid by the KOZK Fordland Reassign and KOZJ Joplin Reassign budgets funded from the Federal Communications Commission Reimbursement Fund ($101,187.00).
VI.D.

RECOMMENDED ACTION - Approval of consultant and authority to enter into an agreement for professional services in conjunction with the tower reinforcement for the KOZK television station.

The following resolution was moved by ________________________________ and seconded by ________________________________:

BE IT RESOLVED by the Board of Governors of Missouri State University that the professional services of Tower Consultants, Inc. in conjunction with the tower reinforcement for the KOZK television station be accepted, approved, and awarded.

BE IT FURTHER RESOLVED that Tower Consultants, Inc. perform this work for a fixed not-to-exceed fee of One Hundred Two Thousand Forty and 00/100ths dollars ($102,040.00) plus reimbursable expenses.

BE IT FURTHER RESOLVED that this be paid by the KOZK Fordland Reassign budget funded from the Federal Communications Commission Reimbursement Fund.

BE IT FURTHER RESOLVED that the Vice President for Administrative Services or the University Architect and Director of Planning, Design & Construction be authorized to sign the agreement with the firm selected, incorporated herein by reference, and perform those acts necessary to carry out and perform the terms of the agreement.

VOTE: AYE _____

NAY _____

COMMENTS:

Following a recent study of the current KOZK television station tower by Tower Consultants, Inc., it was found that the tower would fail when subjected to current structural standards for broadcast towers and antennas. The University is looking for professional assistance with reconstructing the tower. This will include the structural modifications necessary to replace the transmission line within the construction documents and specifications. Additionally, the consultant will assist the University in the bidding and contractor selection process, review submittal drawings, observe work, generate progress reports, and produce record drawings.

Upon Federal Communications Commission approval, this project will be paid by the KOZK Fordland Reassign budget funded from the Federal Communications Commission Reimbursement Fund ($102,040.00).
VI.E.
RECOMMENDED ACTION – Approval of lease agreement for radio tower space for KSMU-West Plains between Missouri State University and Tom and Shawn Marhefka.

The following resolution was moved by ________________________ and seconded by ________________________.

WHEREAS, the University operates a public radio station KSMU; and

WHEREAS, KSMU requires radio tower space in West Plains, Missouri, for the purpose of transmitting KSMU programming to the West Plains, Missouri market; and

WHEREAS, Tom and Shawn Marhefka have agreed to lease tower space to the University for Seven Hundred Dollars ($770.00) per month or Nine Thousand Two Hundred and Forty Dollars ($9,240) per year; and

WHEREAS, the proposed five year lease agreement will take effect October 1, 2017 and will expire on September 30, 2022.

NOW, THEREFORE, BE IT RESOLVED by the Board of Governors for Missouri State University that this lease agreement be approved and that the Vice President for Administrative Services be authorized to sign said lease agreement.

VOTE: AYE _______

NAY _______

Comments: This is a five year lease, which provides radio tower space for KSMU in West Plains, Missouri.
TELECOMMUNICATIONS SITE LEASE

THIS LEASE, made as of the 1st day of October 2017 between;

Name and address of Lessor;
Tom & Shawn Marhefka
PO Box 1007
West Plains, MO 65775
Attn: Tom Marhefka
PH: (417) 256-1025
tjmarhefka@me.com

Name and address of Lessee;
Board of Governors of Missouri State University
Missouri State University
901 South National Avenue
Springfield, Missouri 65897
Attn: Tammy Wiley
PH: (417) 836-6634
TammyWiley@missouristate.edu

RENT: $770.00/month or $9,240.00/year for the Term of this agreement.

TERM: Five (5) Years commencing 10/1/2017 (Commencement Date) and ending on the last day of the month which completes the term of the year aforesaid (9/30/2022).

EQUIPMENT: Specifically listed in Exhibit # 1 of this agreement.

LOCATION OF LESSOR’S PROPERTY:
Street address: 983 East US Highway 160
City, State, Zip: West Plains, MO 65775
Phone Number: 417-256-1025 // Email tjmarhefka@me.com
Contract: Tom Marhefka, President / Jim White, Chief Engineer

LEASED PREMISE:
Site Name: Tom & Shawn Marhefka Tower – West Plains
Site ID# 1005437
Latitude: N36-44-48.6 Longitude: W91-49-56.3 Ground Level: 329.2 meters
Tower height: 125.3 meters (AGL)
TABLE OF CONTENTS:

General Terms and Conditions (Pg. 3 through Pg. 9)

Exhibit 1: (Pg. 10)
   Equipment

Exhibit 2: (Pg. 11)
   Frequency
GENERAL TERMS AND CONDITIONS

1. LEASE OF LEASED PREMISES. Lessor agrees to lease the Leased Premises to Lessee as described on page one of this Agreement.

2. USE OF LEASED PREMISES. The Leased Premises are to be used for the installation, operation and maintenance of messaging equipment, including base stations, antenna poles or masts, cabling or wiring, and accessories used therewith. Lessee and its subtenants and lessees shall have the unrestricted right to enter or leave the Leased Premises at all reasonable times. Lessee may not sublet or lease to others to use the Leased Premises and may make minor alterations to it without Lessor’s consent. Lessee reserves the right to choose the company(ies) that will install and/or maintain its equipment with Lessor’s approval. All equipment or other property attached to or otherwise brought onto the Leased Premises shall at all times be personal property.

3. TERM. The term of this lease is indicated on page one of this Agreement unless otherwise indicated in the Specific Terms and Conditions. Lessee shall have the option to renew this lease for a like period under the same terms and conditions contained in this lease by mailing written notice to Lessor at least sixty (60) days before the expiration of the term indicated on page one of this Agreement. If the site becomes unfit or undesirable for use for Lessee’s purposes, Lessee may terminate this lease by emailing written notice to Lessor which shall be effective ninety (90) days after it is mailed by Lessee. If Lessee holds over at the end of the term, it shall create a month to month tenancy subject to the provisions of this lease. If the Lessee is unsatisfied with the site for reasons of radio frequency coverage or other technological complications, Lessee may terminate this Agreement; provide, however (i) Lessee has provided the Lessor with at least (90) days prior written notice of such termination; (ii) Lessor is not in default; and (iii) the Lessee shall remove any and all of its equipment and shall have paid any rent or other fees due Lessor through the termination date.

4. RENT. Each month during the term of this lease and while Lessor is not in default hereunder Lessee will pay to Lessor in advance the monthly rental indicated on page one of this Agreement.

5. LIABILITY. As a Missouri public institution of higher education, Lessee does not maintain commercial general liability insurance. Rather, it relies on the State Legal Expense Fund, as established by Mo. Rev. Stat. § 105.711 and as administered by the Missouri Attorney General Office. Lessee agrees to provide Lessor with written confirmation of same upon request.

6. UTILITIES. Electricity and other utilities are to be paid and provided by Lessor unless otherwise indicated in the Specific Terms and Conditions.

7. TAXES. Lessor shall be responsible for the declaration and payment of any applicable taxes or assessments against the Property owned by Lessor. Lessee agrees to pay all such taxes which are assessed against the Lessor and/or the Lessee due to the personal property
and improvements constructed or maintained by Lessee on or about the Leased Premises; provided, however, Lessee shall have the right to prior notification of any taxes for which it is to be charged, so as to be given the opportunity to appear before the taxing authority and contest said assessment.

8. INDEMNIFICATION. To the extent permitted by law, and without waiving its sovereign, official, or governmental immunity, Lessee, its partners, contractors, agents, and employees agree to indemnify, hold harmless and defend Lessor, its partners, tenants, contractors, agents, and employees from and against any and all losses, claims, liabilities and expenses, including reasonable attorney fees, if any, which Lessor, its partners, tenants, contractors, agents, and employee’s use of the Premises, excluding such claims as may arise from the acts or negligence of Lessor, its partners, tenants, contractors, agents, and employees.

Lessor, its partners, tenants, contractors, agents, and employees agree to indemnify, hold harmless and defend Lessee, its partners, contractors, agents, and employees from and against any and all losses, claims, liabilities and expenses, including reasonable attorney fees, if any, which Lessee, its partners, contractors, agents, and employees may suffer or incur in connection with Lessor, its partners, tenants, contractors, agents, and employees use of the Premises, excluding such claims as may arise from the acts or negligence of Lessee, its partners, contractors, agents, and employees.

9. ENVIRONMENTAL. Lessor shall protect, defend, indemnify and hold Lessee and its affiliates and the directors, officers, employees, agents, successors, and assigns of any of them, harmless from and against any and all claims, fines, judgments, penalties, actions, abatement, cleanup, remediation, testing, investigations, losses, damages, costs, expenses or liability (including attorneys’ fees and costs) directly or indirectly arising out of or attributable to the use, generation, manufacture, production, storage, release discharge, disposal, or presence of a Hazardous Material on, under or about the Leased Premises or Lessor’s Property; except to the extent caused by the active negligence or willful misconduct of Lessee. Lessor shall ensure that itself and all other lessees comply with all Environmental Laws. This indemnity shall survive the expiration or termination of this Lease.

RF Emission Exposure Compliance. Lessee must be able to certify to the Federal Communications Commission (FCC) that site radio frequency (RF) emission exposure is below the Maximum Permissible Exposure (MPE) limits stated in its Office of Engineering & Technology (OET) Bulletin 65. To that end, Lessor agrees to assist Lessee in compliance determination by providing information as requested by Lessee. Further, Lessor agrees to help Lessee maintain compliance by informing Lessee of equipment changes and additions by other lessees. Lessor agrees to report known violations of site safety procedures to Lessee.

Environmental Laws. “Environmental Laws” mean all applicable present and future statutes, regulations, rules, ordinances, codes, licenses, permits, orders, approvals,
plans, authorizations, concessions, franchises and similar items of all governmental agencies, departments, commissions, boards, bureaus or instrumentalities of the United States, states and political subdivisions thereof and all applicable judicial and administrative and regulatory decrees, judgments and orders relating to the protection of human health or the environment, including, without limitation: all requirements, including but not limited to those pertaining to reporting, licensing, permitting, investigation and remediation of emissions, discharges, releases or threatened releases of Hazardous Materials (as defined below), chemical substances, pollutants, contaminants or hazardous or toxic substances, materials, or wastes whether solid, liquid or gaseous in nature, into the air, surface water, groundwater or land, or relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport or handling of chemical substances, pollutants, contaminants or hazardous or toxic substance, material, or wastes, whether solid, liquid or gaseous in nature.

Hazardous Materials. “Hazardous Material” means any substance: (i) the presence of which requires investigation, regulation or remediation under any federal, state or local statute, regulation, ordinance, order, action, policy or common law; (ii) which is or becomes defined as a “hazardous substance” under federal, state or local statute, regulation or ordinance or amendments thereto including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act (42 U.S.C. Section 9601 et seq.), and/or the Resource Conservation and Recovery Act (42 U.S.C. Section 6901 et seq.); (iii) which is toxic, explosive, corrosive, flammable, infectious, radioactive, carcinogenic, mutagenic, or otherwise hazardous and is or becomes regulated by any governmental authority, agency, department, commission, board, agency or instrumentality of the United States, the State where the premises are located or any political subdivision thereof; (iv) which contains gasoline, diesel fuel or other petroleum hydrocarbons; or (v) which contains polychlorinated biphenyls (PCBs), or asbestos-containing materials.

Environmental Notices. Lessor shall give prompt written notice to Lessee of (i) any proceeding or inquiry by any governmental authority with respect to the presence of any Hazardous Material on the Premises or Lessor’s Property or the migration thereof from or to other property; (ii) all claims made or threatened with respect to the Property by any third party against Lessor or Lessee relating to any loss or injury resulting from any Hazardous Materials; (iii) any spill, release, discharge or disposal of Hazardous Materials that occurs with respect to Lessor’s/Lessee is required to give notice.

10. CONDEMNATION/DESTRUCTION OF PROPERTY/LEASED PREMISES. If the Property or Leased Premises are, in whole or in part, destroyed by fire or other elements, or condemned by public authorities, whether by eminent domain or otherwise, then (1) if wholly destroyed or condemned so that all of the Leased Premises are rendered untenable, the lease shall then terminate, and Lessee shall be liable for the rent only up to the time of such destruction or condemnation and the rent prepaid by Lessee shall be returned to it; but (2) if only partially destroyed or condemned, and still tenable, Lessor shall, within thirty days, repair said premises with a reasonable reduction of rent from the time of such partial destruction or condemnation until the Leased Premises be again of reasonable value to Lessee as the premises were before partially destroyed or condemned; provided, however, that if such partial destruction or condemnation shall occur within six (6) months prior to the termination of this
lease, then this lease, if Lessee so elects, shall then terminate and Lessee shall be liable for rent only up to the time of such destruction or condemnation and any rent prepaid by Lessee shall be returned to it. A decision as to whether partially destroyed or partially condemned premises are still tenantable as provided herein, shall be made jointly by Lessor and Lessee, and if they cannot agree, by an arbitrator agreeable to both parties.

11. LESSOR’S MAINTENANCE. During the term of this Lease, Lessor shall keep the Leased Premises and the Property owned by Lessor of which they are a part in good condition and repair. However, such maintenance and repairs should be done in a manner so as to not interfere with Lessee’s use of Leased Premises.

12. CONDITON AND SURRENDER OF SITE. Upon termination or expiration of this lease Lessee will surrender the Leased Premises to Lessor in good condition except (a) for reasonable wear and tear, or (b) for damage due to causes beyond Lessee’s control or without its fault or negligence, or (c) for both.

13. PAINTING AND LIGHTING. Lessor acknowledges that it, and not Lessee, shall be responsible for compliance with all tower or building marking and lighting requirements, which may be required by the Federal Aviation Administration (“FAA”) or the Federal Communication Commission (“FCC”). Further, Lessor is responsible for all up keep and maintenance of tower/building painting and lighting specifications set forth by the FCC and the FAA. Lessor shall remain aware of all FCC/FAA rules and regulations that will affect his/her tower or building. Lessor shall indemnify and hold harmless Lessee from any fines or other liabilities caused by Lessor including failure to comply with such requirements. In the event that any fines are imposed due to the FCC/FAA specifications not being met, it will be the Lessor’s sole responsibility to pay these fines. The Lessor will be solely responsible for bringing the lighting and/or painting up to FCC/FAA requirements within the set time they allow. Should Lessee be cited by either the F.A.A. or the F.C.C. because this site is not in compliance within the time frame allowed by the citing agency, Lessee may terminate this Agreement immediately upon notice to Lessor.

14. ASSIGNMENT OF LEASE. Lessor or Lessee may assign this lease with the other party’s written consent, which consent shall not be unreasonably withheld or unduly delayed. Notwithstanding the foregoing, Lessee may assign this Lease without Lessor’s consent to any of the following: (i) any corporation, partnership or other entity which controls, is controlled by or under common control with Lessee; (ii) any corporation or other entity resulting from the merger or consolidation of Lessee; (iii) any corporation, partnership, or other entity, or person which acquires all or substantially all of the assets, provided that such assignee assumes in full the obligations of Lessee under the Agreement.

15. DEFAULTS. Lessee shall have fifteen (15) days after receipt of written notice to cure any monetary default and thirty (30) days after receipt of written notice to cure any monetary default and thirty (30) days after receipt of written notice to cure any non-monetary default; provided however, that if any default is not capable of being cured within the requisite period of time, then so long as the party charged with the default has diligently pursued such cure of the default within the prescribed period, the party shall be given the necessary time
to cure the default. If there shall occur an Event of Lessor Default, Lessee shall upon thirty (30) days written notice terminate this Agreement and institute any other proceedings at law or in equity to recover damages from Lessor, provided however, that if any default is not capable of being cured within the requisite period of time, then so long as the party charged with the default has diligently pursued such cure of the default within the prescribed period, the party shall be given the necessary time to cure the default.

16. EQUIPMENT INSTALLATION AND MAINTENANCE. The equipment listed on Exhibit one (1) of this Agreement shall be installed by Lessee. The equipment shall be installed in accordance with Lessor’s specifications and standards and maintained in good working order. It is expressly agreed and understood that Lessee’s equipment shall be installed and maintained so as not to interfere in any manner whatsoever with the equipment of Lessor or any other lessee operating and maintaining its equipment on the premises of Lessor at the time of installation, and so as to meet all applicable FCC regulations and conditions of its license. The installation of the aforesaid equipment shall be made by Lessee by means without weakening or damaging in any nature the Property of the Lessor.

ADDITIONAL EQUIPMENT. Lessor shall grant to Lessee the right to install additional equipment at any time during the primary term or renewal thereof by Lessee providing Lessor thirty (30) days prior written notice and a negotiated increase in rent. In the event Lessor cannot accommodate Lessee’s additional equipment, then Lessee shall have the option in its sole discretion to terminate this agreement and have no further obligation thereunder. Any additional equipment may result in additional rent to be charged to Lessee.

17. ELECTRICAL INTERFERENCE. Lessor and Lessee agree that due to the nature of Lessor’s business some electromagnetic interference may be generated within the building housing Lessee’s equipment. In the event this electromagnetic interference causes Lessee’s equipment to malfunction, Lessee shall immediately notify Lessor in writing at which time Lessor shall make an effort to eliminate, reduce or filter out the interference. Lessor shall not make any alteration or modification to lessee’s equipment including transmission lines or antenna locations without the expressed written consent of Lessee; however Lessee shall make available to Lessor technical information on Lessee’s equipment and on the type of interference being experienced to assist Lessor in eliminating, reducing or filtering out the interference. In the event Lessor is unable to eliminate the interference, or reduce it to a level acceptable to Lessee, within a period of thirty (30) days then Lessee may terminate this Agreement.

In the event that Lessee’s equipment causes interference to existing lessees, Lessor shall immediately notify Lessee in writing at which time Lessee shall make an effort to eliminate, reduce or filter out the interference.

In addition Lessee shall have the right to terminate this agreement upon ninety (90) days written notice should its reception or transmission be interfered with or affected by other antenna and equipment, or by obstacles such as buildings, additions, towers or other structures which might be constructed or maintained in Lessee’s receiving or transmitting...
paths after the date of this agreement. Neither Lessor nor Lessee shall have any further obligation under this lease other than Lessee's obligation to remove all of its equipment from the premises.

18. NOTICES. Any notice or demand required or permitted to be given or made hereunder shall be sufficiently given if made by certified mail in a sealed envelope, postage prepaid, addressed to Lessor or Lessee, as applicable, to their respective addresses as set forth on the page one of this Agreement. Any such notice or demand shall be deemed to have been given or made at the time it is deposited in the United States Post Office. Lessee or the Lessor may from time to time designate any other address for this purpose by written notice to the other party.

19. WAIVER. Failure or delay on the part of Lessee or the Lessor to exercise any right, power or privilege hereunder shall not operate as a waiver thereof.

20. PRIOR NEGOTIATIONS. This lease constitutes the entire Agreement of the parties hereto and shall supersede all prior offers, negotiations and agreements.

21. AMENDMENT. No revision of this lease shall be valid unless made in writing and signed by an officer of Lessee and an authorized agent of Lessor.

22. GOVERNING LAW. This Agreement is governed by the laws of the State of Missouri.

23. SEVERABILITY. If any provision of this Agreement shall be invalid or unenforceable with respect to any party, the remainder of this Agreement, or the application of such provision to persons other than those as to which it is held invalid or unenforceable, shall not be affected and each provision of the remainder of the Agreement shall be valid and be enforceable to the fullest extent permitted by law.

24. FORCE MAJEURE. Lessee shall not be liable if its performance of the Agreement becomes commercially impracticable due to any contingency beyond the Lessee's reasonable control ("Force Majeure"), including, but not limited to, acts of God, fires, floods, wars, sabotage, civil unrest, labor disputes, government laws, rules and regulations, whether valid or invalid.

25. TIME IS OF THE ESSENCE. Should this agreement not be executed by the Lessor within thirty (30) days of receipt by Lessor or its agents, partners, or representatives, Lessee may, but is not obligated to, cancel this Lease. Additionally, any requests by Lessee should be processed in a timely manner. If Lessor does not communicate with Lessee in a timely fashion, that is considered to be a default.
IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement the day and year first written above.

LESSOR

Tom & Shawn Marhefka

[Signature]

Shawn Marhefka

LESSEE

Board of Governors of Missouri State University

[Signature]

Its: ______________________
EXHIBIT #1

Description of Equipment

1 two bay ERI antenna at 354 feet
1 Main transmitter-Harris
1 backup transmitter BE
1 Harris Intralplex T1 unit
1 optimod
1 Burk ARC 16
1 coaxia switch
1 daysequerra M2
1 daysequerra M3
EXHIBIT #2

Frequency used:

- Transmit frequency is 90.3 FM
April 17, 2017

RE: Request for Proof of Insurance

To Whom It May Concern:

This certifies that Missouri State University, its agencies, officials and employees are protected from causes of action under Missouri law and all other courts of competent jurisdiction to the extent as defined by the State Legal Expense Fund, Chapter 105.711 RSMo.

This fund is administered cooperatively by this office and the Office of Attorney General.

Any claim against Missouri State University, its agencies, officials or employees should be made to this office.

Sincerely,

Jacinda A. Thudium
Risk Manager
Risk Management Section
573/751-4044
573/751-7819 fax
RECOMMENDED ACTION – Approval to enter into Lease Agreement at Jordan Valley Innovation Center (JVIC).

The following resolution was moved by _____________________________ and seconded by _____________________________.

WHEREAS, the University and ESM Technologies, Inc. (“ESM”) have an existing Lease Agreement dated September 1, 2016 (“Lease”) (attached hereto);

WHEREAS, Tenant and Landlord desire to extend the term of the lease and wish to set forth the terms for such extension.

WHEREAS, the parties desire to extend ESM’s Leased Space for a period of 12 months commencing on September 1, 2017 and expiring on August 31, 2018.

WHEREAS, the Amendment provides for twelve month renewals by agreement, and the lease rate is will be adjusted proportionately to changes as reflected in the most currently available Consumer Price Index for Kansas City, Missouri, over the month in which the Lease commenced.

NOW, THEREFORE, BE IT RESOLVED by the Board of Governors of Missouri State University that Amendment #1, attached hereto, between Missouri State University (“Landlord”) and ESM Technologies (“Tenant”) at the Jordan Valley Innovation Center located at 524 North Boonville Avenue, Springfield, MO be approved and that the Vice President for Administrative Services be authorized to sign said Amendment and renewals on behalf of the Board of Governors.

VOTE: AYE ________

NAY ________

COMMENTS: Amendment #1 allows ESM Technologies, Inc. to extend the lease of shared space on the 6th floor of Buildings 1 and 2 and sets up automatic twelve month renewals going forward.
AMENDMENT #1 TO LEASE AGREEMENT

This Amendment #1 to Lease Agreement is entered into effective the 20th day of September 2017, by and between the Board of Governors of Missouri State University ("Landlord") and ESM Technologies, Inc., a Missouri corporation, hereinafter "ESM" or "Lessee" or "Tenant".

RECITALS

WHEREAS, Landlord and Tenant are parties to a Lease Agreement dated September 1, 2016 and

WHEREAS, Tenant and Landlord desire to extend the term of the lease and wish to set forth the terms for such extension.

NOW, THEREFORE, for good and valuable consideration, receipt of which is hereby acknowledged, the parties hereby agree as follows:

1. TERM: Article II, Section 2 delete and replace with:
   a. The term of the Lease is hereby extended for a period of 12 months commencing on September 1, 2017 and expiring on August 31, 2018 unless extended or earlier terminated pursuant to the lease.
   b. This Lease may be extended for additional 12 month renewal terms, on the terms as set forth in this Lease Agreement, by written notice from Lessee to Lessor at least thirty (30) days before the end of the then current term; provided however that for each successive renewal term the annual rental payment shall adjust proportionately to changes as reflected in the most currently available Consumer Price Index for Kansas City, Missouri, over the month in which the Lease commenced, and provided Landlord agrees in writing to the extensions within thirty (30) days of receiving notice of extension.

2. RATIFICATION: Except as expressly modified by this Amendment, all terms and provisions of the Lease, as previously amended, shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Amendment to Lease Agreement effective as of the date first set forth above.

Landlord: 

The Board of Governors of Missouri State University 

By: ________________________________

Tenant: 

ESM Technologies Inc.

By: ________________________________
LEASE AGREEMENT

This Lease Agreement ("Lease"), made and entered into this 1st day of September 2016 ("Effective Date"), by and between the Board of Governors of MISSOURI STATE UNIVERSITY ("University" or "Lessor") and ESM Technologies, Inc., a Missouri corporation, ("ESM" or "Lessee").

WHEREAS, on or about April 18, 2013, University and ESM executed a lease whereby ESM leased certain shared space in the University's eFactory, located at 405 North Jefferson Avenue, Springfield, Missouri ("Prior eFactory Lease");

WHEREAS, the Prior eFactory Lease is scheduled to continue through May 14, 2017;

WHEREAS, on or about December 1, 2014, University and ESM executed a lease whereby ESM leased certain shared lab workspace in University's Jordan Valley Innovation Center, located at 524 N. Boonville Ave, Springfield, Missouri. ("Prior JVIC Lease");

WHEREAS, the Prior JVIC Lease is scheduled to continue through November 30, 2016 and, thereafter, is subject to renewal by mutual agreement;

WHEREAS, both the Prior eFactory Lease and the Prior JVIC Lease are terminated, superseded, and replaced by the Lease as of the Effective Date.

WITNESSETH:

Article I. Scope of Work - Lessee agrees to lease space at the Jordan Valley Innovation Center, 524 N. Boonville Ave, Springfield Missouri, as further described in Article II, below.

Article II. Lease Agreement for the Premises

Section 1. Demise

a. Upon the terms and conditions hereinafter expressed, Lessor hereby leases to the Lessee shared lab workspace and shared lab office space on the sixth floor of buildings one and two described on Exhibit 1 (the "Premises") located in the Jordan Valley Innovation Center building ("Shared Space") located at 524 N. Boonville Ave, Springfield, Greene County, Missouri.

Lessee shall have the non-exclusive right with others designated by Lessor to the free use of the common areas in the building of the Shared Space and the Land on which the building is located for the intended and normal purposes of such common areas. As used herein, "common areas" include elevators, sidewalks, parking areas, driveways, hallways, stairways, public bathrooms, common entrances, lobby and other similar public areas and access ways. Lessor may make any changes or modifications to the common areas provided that such changes shall not materially and
unreasonably interfere with the Lessee’s access to the Premises or use of the Premises for the purposes permitted hereunder.

Section 2. Term

a. This Agreement shall be for one (1) year commencing September 1, 2016 and ending August 31, 2017.

Section 3. Rent; additional Rent and late charges

(1) For the use and occupancy of the Premises during the term hereof, Lessee shall pay to Lessor monthly rent of Two Thousand Nine Hundred Eleven Dollars and Sixty-One Cents ($2,911.61). Subject to Section 3(2) below. Rent shall include utilities, data and two telephones.

(2) In the event that Lessee requests that Lessor provide additional communications systems within the Premises, Lessee shall be billed separately for the costs associated with Lessor’s provision of the same.

(3) Anything in this lease agreement to the contrary notwithstanding, at Lessor’s option, Lessee shall pay as additional rent a “late charge” of five percent (5%) of any installment of rental (or any such other charge or payment as may be considered additional rental under this lease agreement) when paid more than ten (10) days after the due date thereof, to cover the extra expense involved in handling delinquent payments. Payment is due 30 days from date of invoice.

Section 4. Use of Premises

a. Lessee covenants to use the Premises to conduct research, product development and normal business operations, and for no other purposes whatsoever without the prior written consent of Lessor. Lessee shall endeavor not to disrupt the other Lessee’s normal working activities and will use its best efforts to cooperate in sharing the Shared Space. Lessee shall not use anyone else’s supplies without permission.

b. Lessor makes no warranty, either express or implied, that the Premises are suitable for the Lessee’s purposes. The Lessee acknowledges and agrees that Lessor has made no representations or agreements with respect to the Premises except as herein expressly set forth. Prior to the Commencement Date, the Lessee shall have examined the Premises and shall be deemed to have accepted the Premises in the then-current physical condition thereof.

c. The Lessee shall not use, or permit the use of, the Premises, or any part thereof, for any unlawful or illegal purpose. In the use of the Premises, the Lessee shall comply with all applicable laws, ordinances, rules, regulations and orders of all governmental authorities or agencies and with any order or direction of any public officer or law which shall impose any obligation or duty on the Lessee with respect to the Premises, the use and occupancy thereof.
d. i.) Lessee must at all times keep the Premises and any improvements insured for full replacement cost under an all-risk property damage policy acceptable to Lessor, and also maintain commercial and general liability insurance with limits acceptable to Lessor in standard insurance form. In no event shall such liability limits be less than One Million Dollars ($1,000,000) per occurrence with excess/umbrella coverage of not less than Two Million Dollars ($2,000,000) per occurrence/aggregate. Lessee must maintain coverage for environmental hazards as may be applicable, in amounts sufficient to protect the University as specified in Section 4.d.ii below. Lessee must also maintain Worker’s Compensation insurance as required by law. Lessor, as a public entity of the State of Missouri, shall maintain a property damage insurance policy, secondary to any insurance provided by Lessee, on terms as applicable to other University’s facilities, provided that the insurance policy obtained through the State of Missouri provides coverage for leased premises. Lessor represents it is a public entity of the State of Missouri and is protected by the Missouri State Legal Expense Fund, as established by Mo. Rev. Stat. § 105.711 and as administered and interpreted by the Attorney General of the State of Missouri. Lessor is subject to the State of Missouri’s Worker’s Compensation self-insurance program, as administered by the Missouri Office of Administration, Central Accident Reporting Office (“CARO”).

ii.) All required insurance must be in standard form(s) and amount(s) sufficient to protect the University and the general public against any loss, damage and/or expense that may occur as a result of the Lessee’s performance under the contract. All such insurance must indemnify the University to the fullest extent possible under the laws of the State of Missouri. Evidence of self-insurance coverage or of another alternate risk financing mechanism may be utilized, provided that such coverage is verifiable and irrevocably reliable.

iii.) Should Lessee install additional security, Lessee’s contracted security firm shall notify Lessor’s Office of Safety and Transportation of any alerts, and comply with the direction of that Office.

iv.) Either party may terminate the Lease without penalty upon 60 days prior written notice.

vi) Lessee may bring visitors into JVIC for short periods of research not to exceed 30 days. Lessee and any visitor will comply with all applicable University policies and laws regarding such visitors, particularly including ITAR (U.S. International Traffic in Arms Regulations), EAR (U.S. Export Administration Regulations), and OFAC (U.S. Office of Foreign Assets Control).

Section 5. Maintenance, Repairs and Improvements; Liens

a. Lessee shall not cause or permit any waste, damage or injury to any part of the Premises, and the Lessee shall, at Lessee’s sole expense (except as otherwise provided herein), maintain the Premises and fixtures in good order. Lessee shall, at Lessee’s sole expense, repair promptly any damage to the Premises or the Building or any part of either thereof to the extent caused by or resulting from misuse or negligence by Lessee or its employees, agents or invitees.
b. Lessee shall not make any alterations, modifications or improvements to the Premises without the prior written consent of Lessor, which consent shall not be unreasonably withheld or delayed or conditioned. All such alterations, modifications and improvements shall become and remain the properties of Lessor and shall not be removed by Lessee. All such repairs, alterations, modifications or improvements shall be made at Lessee’s sole expense, and all costs therefore shall be paid promptly when due. All such repairs, alterations, modifications and improvements shall be performed promptly, efficiently and competently by duly qualified or licensed persons. Lessee shall not permit any mechanics’ or other liens resulting from any labor, materials, equipment or supplies furnished with respect to the Premises at the request of Lessee to stand against the Premises, the Building or the Land, and any such liens shall be paid and satisfied promptly by Lessee unless Lessee shall post a bond equal to the amount of the disputed claim with a bonding company reasonably satisfactory to Lessor. If Lessee posts such a bond, it shall contest the validity of the lien.

c. Except for repairs and replacements required to be made by Lessee pursuant to Section 5 (a), herein, Lessor shall make, at its expense, all other repairs and replacements to the common areas and Building (including Building fixtures and equipment) as may be necessary from time to time to maintain the Building in a condition comparable to other buildings on the University campus. Such maintenance shall include the roof, structural portions, outside walls, common areas, elevators, and other “White Box” conditions. Lessor will be responsible for maintenance of all infill conditions. Lessor shall not be required to make such repairs as Lessee is required to make under the provisions of Section 5 (a); provided, however, that if Lessee shall fail to make such repairs within a reasonable time, then Lessor may, but shall not be required to, make such repairs, and if Lessor makes such repairs, Lessor shall promptly reimburse Lessee its cost therefore upon receipt of an invoice from Lessor. Lessee shall report in writing to Lessor, within two (2) business days of discovery by Lessee, any defective condition within the Premises known to the Lessor which Lessee is required to repair, and Lessor shall not be liable to Lessee or its employees, agents or invitees for any such defective condition unless and until Lessee has made such report.

d. There shall be no allowance to Lessee for a diminution of rental value, and Lessor shall have no liability to Lessee, by reason of any inconvenience, annoyance, interruption or injury to business arising from the making of any repairs, alterations or improvements which Lessor is required or permitted by this Lease, or required by law, to make in or to any portion of the Building or the Premises, or in or to the fixtures, equipment or appurtenances of the Building or the Premises.

e. At such time as the Lessee determines a requirement to vacate the premises, Lessee may remove specialized, Lessee-installed equipment. Any damage caused to the premises by such installation or removal of the equipment must be repaired and the premises restored to its original condition.

Section 6. Lessee’s Personal Property - Lessee shall, at Lessee’s sole expense and risk, provide all furniture, furnishings, fixtures, equipment and other personal property necessary or desirable in connection with the use of the Premises. Lessee may install in the Premises any such property which shall remain the personal property of Lessee, except for fixtures attached to the Building, which will become the property of Lessor, unless identified, provided, however, that Lessee shall
repair any damage to the Premises caused by the removal of any such equipment. Lessor shall have no obligation to provide, maintain or replace any such furniture, furnishings, fixtures, equipment or other personal property. No such furniture, furnishings, fixtures, equipment or other personal property shall be installed which affect the structural integrity or external appearance of the Premises. Lessee shall, at Lessee's sole expense, promptly repair any damage to the Premises caused by or resulting from the installation or removal of any personal property of Lessee. Lessee shall be responsible for insurance or self-insurance on such personal property and for the payment of any taxes assessed with respect to such personal property. Lessor shall not be liable or responsible in any way for any loss or damage to or insurance or taxes on any such personal property.

Section 7. Services

a. Lessor will, so long as Lessee is not in default under any of the provisions of this Lease, at the proper seasons and during reasonable hours (or as specified below), furnish the services set forth in Exhibit 3 below, and in addition thereto;

(1) Maintain the common areas in a manner comparable to other buildings on the University campus, including usual and customary cleaning, HVAC, illumination, snow removal, de-icing, repairs, replacements, lawn care and landscaping. Lessee shall be responsible for all other services not specified relating to the Premises.

b. Except as provided in Section 7(c) below, Lessor shall not be liable for damages, by abatement of rent or otherwise, for failure to furnish or delay in furnishing the services referred to in this section when such failure to furnish or delay in furnishing is occasioned in whole or in part by any strike, lockout or other labor controversy, or by any accident or casualty whatsoever, or by the act or default of Lessee or other parties, or by any cause or causes beyond the reasonable control of Lessor, which shall not be considered or construed as an actual or constructive eviction of Lessee, nor shall such failure in any way operate to release Lessee from the prompt payment of the rent and other amounts due hereunder or the performance of the other covenants and agreements on the part of Lessee contained herein. Without limiting the foregoing, Lessor shall in no event be liable for any consequential, derivative, incidental or special damages, nor any damages in the nature of such damages, resulting from its failure to furnish or its delay in furnishing such services, nor from the aforesaid unauthorized acts or causes, nor any actual damages in excess of an abatement of rent in proportion to the actual period of time in which the Premises were rendered untenable by any such failure or delay, all subject to the provisions of Section 7(c).

c. Notwithstanding the provisions of Section 7(b) above, if any services supplied by Lessor as set forth in 7(a) are interrupted which cause the Premises to be unusable by Lessee, and such interruption does not result from the negligence or willful misconduct of Lessee or its employees, agents or invitees, the Lessee shall be entitled to an abatement of rent. Such abatement shall begin on the third consecutive business day of the interruption, or the day on which Lessee stops using the Premises because of the interruption, whichever is later. Such abatement shall end when the Premises are restored to substantially the same condition as prior to the interruption.
Section 8. Insurance

a. Lessee shall obtain and keep in full force and effect during the term of this Lease, at its expense, insurance as set forth below in Section 8.a.(i)-(v) as modified by Section II.5.d of this Lease Agreement, and shall provide Lessor with a certificate evidencing such insurance, and naming Lessor as an additional named insured. The Lessee shall not violate, or permit the violation of, any condition imposed by any policies of insurance (casualty, liability or other) covering the Building or any part thereof from time to time, and shall not do, or permit anything to be done, or keep or permit anything to be kept in the Premises, which would affect, impair or contravene any policies of insurance that may be carried on or with respect to the Building or any part thereof or which would cause the cost of insurance respecting the Building or the property therein to exceed the cost for such insurance which would otherwise be in effect or which would result in the refusal of insurance companies of good standing to insure the Building or the property of Lessor therein in amounts reasonably satisfactory to Lessor.

(i) Lessee must understand that Lessor cannot save and hold harmless and/or indemnify Lessee or Lessee’s employees against any liability incurred or arising as a result of any activity of Lessee or any activity of Lessee’s employees related to Lessee’s performance under the contract.

(ii) Lessee must maintain all risk property damage and general and commercial liability insurance. All required insurance must be in standard form(s) and amount(s) sufficient to protect the Lessor and the general public against any loss, damage, and/or expense that may occur as a result of Lessee’s performance under the contract. All such insurance must indemnify Lessor to the fullest extent possible under the laws of the State of Missouri. Evidence of self-insurance coverage or of another alternative risk financing mechanism may be utilized, provided such coverage is verifiable and irrevocably reliable.

(iii) Written evidence of the required insurance coverage should be submitted before or upon the award of the contract. Such policy (ies) shall name the Board of Governors of Missouri State University, its officers and employees, as additional named insureds. In the event that the insurance coverage is canceled, the Lessor must be notified immediately.

(iv) Lessee understand and agrees that the insurance required under the terms of the contract in no way precludes the contractor from carrying such other insurance required by law, or as may be deemed necessary by Lessee for the operation of Lessee’s business or for the benefit of Lessee’s employees.

(v) Notwithstanding any other provision of the contract to the contrary, no insurance procured by Lessee shall be construed to constitute a waiver of any sovereign immunity as set forth in Mo. Rev. Stat. § 537.600 et. seq., or any other governmental or official immunity, nor provide coverage for any liability or suit for damages which is barred under said doctrines of sovereign, governmental or official immunity available to Lessor its Board of Governors, officers or employees, not constitute waiver of any available defense; and neither shall such insurance provide coverage for any sums other that those which, Lessor, its Board of Governors, officers
or employees may be obligated to pay as damages.

b. Lessee will additionally maintain professional liability insurance covering its operation in and about the Premises in levels no less than its other similar operations in the state of Missouri, and will hold harmless and defend Lessor against any claim for malpractice or professional negligence against Lessee and its employees or contractors.

Section 9. Destruction or Damage

a. In the event of damage to or destruction of the Premises or access thereto or any part of the Building that provides essential services to the Premises by fire or other casualty, Lessee shall give prompt notice thereof to Lessor, and if such damaged areas can be substantially repaired and restored within one hundred twenty (120) days from the date of discovery of the damage using standard working methods and procedures, Lessor shall, at its expense, promptly and diligently repair and restore such damaged areas to substantially the same condition as existed before the damage, with due allowance for any delay by reason of any cause beyond the control of Lessor. If Lessor determines that such damaged areas cannot be repaired and restored within such one hundred twenty (120) day period, then Lessor shall give prompt written notice thereof to the Lessee, and thereafter either party may, within ten (10) days after the Lessee’s receipt of such notice, cancel this Lease by giving written notice to the other party. Nevertheless, if such repairs and restorations are not substantially completed within such one hundred twenty (120) day period (with due allowance for any delay by reason of any cause beyond the control of Lessor), the Lessee may cancel this Lease by written notice to Lessor at any time after the 120th day and before the 140th day after Lessor’s receipt of the notice contemplated by the first sentence of this Section 9 (a). In the event of any delay in commencing or completing such repairs or restorations by reason of any cause beyond the control of Lessor, such one hundred twenty (120) day period shall be extended for such time as is reasonably necessary to allow Lessor to complete any repairs and restorations so required.

b. So long as its right of full recovery under any policies of insurance is not prejudiced, Lessor hereby waives any and all right of recovery which it might otherwise have against the Lessee, and the Lessee’s servants, agents and employees, for loss or damage occurring to the Building and the fixtures, appurtenances and equipment therein, to the extent the same is covered by Lessor’s insurance, notwithstanding that such loss or damage may result from the negligence or fault of the Lessee, or its servants, agents, employees or invitees. So long as its right of full recovery under any of its policies or insurance is not prejudiced, the Lessee hereby waives any and all right of recovery which it might otherwise have against Lessor and its servants, agents and employees, and against every other tenant in the Building who shall have executed a similar waiver, for loss or damage to the Lessee’s furniture, furnishings, fixtures and other property, to the extent that same is covered by the Lessee’s insurance, notwithstanding that such loss or damage may result from the negligence or fault of Lessor, its servants, agents, employees or invitees, or other tenant.

c. To the extent that the Premises are rendered unsuitable for Lessee’s intended use by any such destruction or damage, the rent payable hereunder to Lessor by the Lessee shall be proportionately abated as to the portion of the Premises rendered unsuitable for Lessee’s intended use from the date of any fire or casualty not caused by the negligence or willful misconduct of the
Lessor or the servants, agents, employees or invitees of the Lessee, until the Premises are repaired. In the event this Lease is terminated pursuant to subsection (a) of this section, the rent payable hereunder shall be abated as of the date of any such fire or other casualty with an equitable refund of rents paid for tenancy after such date.

Section 10. Condemnation

a. If the whole of the Premises shall be taken by condemnation or other eminent domain proceedings, or by conveyance in lieu thereof, by any authority for public use, then this Lease shall automatically terminate effective on the date of such taking. If any part of the Premises or the Building shall be so taken or conveyed so as to materially interfere with Lessee’s ability to continue its operations in substantially the same manner as prior to such taking, then Lessee may terminate this Lease effective on the date when title vests pursuant to such taking or on such later date as Lessee may agree. If such partial taking or conveyance is not so extensive as to so interfere with the operations on the Premises by Lessee, then this Lease shall continue in full force and effect except that the rent provided for herein shall be reduced in proportion to the number of square feet of the Premises no longer available to Lessee, if any, and Lessor shall, upon receipt of the entire condemnation award, make all necessary repairs and alterations so as to constitute the Premises a complete architectural unit, but in no event shall Lessor be required to expend for such purpose more than the entire condemnation award received by it, net of expenses, for that part of the Premises so taken or conveyed. If in the event of any such partial taking or conveyance, in the sole judgment of Lessor, the Building cannot be operated as an economically viable unit, then Lessor may terminate this Lease by written notice to Lessee.

b. In no event shall Lessee be entitled to any part of any condemnation award or damages payable to Lessor for any such taking or conveyance, whether whole or partial, and Lessee expressly waives any claim to such award or damages. Notwithstanding the foregoing sentence, however, the Lessee may claim and recover from the condemning authority a separate award for Lessee’s moving expenses, dislocation damages, personal property and fixtures, the unamortized costs of leasehold improvements paid for by Lessee, and any other award that would not reduce the award payable to Lessor.

Section 11. Assignment, Subleasing and Mortgaging

a. Lessee shall not assign, mortgage or otherwise encumber or transfer this Lease, or sublease, or permit any other entity to use or occupy, all or any part of the Premises without the express prior written consent of Lessor, which consent will not be unreasonably withheld or delayed. The consent by Lessor to any assignment, mortgage, encumbrance, other transfer, sublease or use or occupancy by others shall not relieve Lessee of the necessity of obtaining the express prior written consent of Lessor to any other or further assignment, mortgage, encumbrance, transfer, sublease, or use or occupancy by others. No assignment, mortgage, encumbrance, other transfer, sublease or use or occupancy by others, with or without the consent of Lessor, shall release Lessee from primary liability hereunder for performance of all obligations and agreements of Lessee under this Lease.

b. If this Lease is assigned or otherwise transferred, whether or not in violation of the provisions of this Lease, Lessor may collect rent from any such assignee or other transferee. If the
Premises or any part thereof are sublet or used or occupied by anyone other than Lessee, whether or not in violation of the provisions of this Lease, Lessor may collect rent from any such subtenant or occupant. In either event, Lessor may apply the net amount collected to the rents herein reserved, but no such collection shall be deemed a waiver of any of the provisions of subsection (a) of this section, or the acceptance by Lessor of the assignee, other transferee, subtenant or occupant as tenant, or a release of Lessee from the performance by Lessee of all obligations and agreements of Lessee under this Lease.

Section 12. Bankruptcy - This Lease shall not be assignable or transferable on the part of Lessee by operation of law or by or as a result of any act of bankruptcy, reorganization, receivership or assignment for the benefit of creditors, or the like, on the part of Lessee. Upon the occurrence of any act of bankruptcy, reorganization, receivership or assignment for the benefit of creditors, or the like, on the part of Lessee, this Lease shall terminate immediately, and the Premises shall be surrendered to Lessor, which reserves the right to enter and repossess the Premises; provided, however, that if any act of bankruptcy, reorganization, receivership or assignment for the benefit of creditors or the like, on the part of Lessee which is not volitional on the part of the Lessee shall be set aside within sixty (60) days of the date of entry thereof, this Lease shall continue in full force and effect.

Section 13. Access and Changes

a. Lessor and its authorized agents may enter the Premises at reasonable hours following reasonable prior notice to Lessee (or any time in the event of an emergency) to make repairs to the Premises or to any adjoining space and to inspect, maintain and clean the Premises. No locks or security systems for the Premises shall be changed without the prior written consent of Lessor. Should Lessee install additional security, Lessee's contracted security firm shall notify Lessor's Office of Public Safety of any alerts, and comply with the direction of that Office.

b. Lessor may erect, use and maintain pipes, ducts and conduits in and through the Premises, provided the same are installed and concealed behind walls and ceilings of the Premises and are installed at such times, by such methods and at such locations as will not materially interfere with or impair Lessee's use of the Premises or damage the appearance thereof.

c. Lessor reserves the right to make, at any time, without incurring any liability to the Lessee therefore, such other changes in or to the Building and the fixtures and equipment thereof, as well as in or to the entrances, halls, passages, elevators and stairways thereof and the public areas therefore, as it may deem necessary or desirable.

d. Lessor shall be allowed to take all material into and upon the Premises that may be required for any work, repairs or changes to be made by Lessor as is required for such purpose without being deemed thereby to have evicted Lessee in whole or in part, and provided that Lessor diligently proceeds therewith and exercises reasonable diligence so as to minimize disturbance to Lessee, the rent herein reserved to Lessor shall in no way abate while said repairs or alterations are being made by reason of loss or interruption of the business of Lessee because of the prosecution of any such work.

Section 14. Notice of Claims - Lessee shall give prompt written notice to Lessor of any accident,
injury or damage of which Lessee is aware occurring in or about the Premises.

Section 15. Acceptance of Payments by Lessor - The acceptance by Lessor of rent or any other payment, or of a lesser amount than the total amount of rent or other payment due hereunder, with knowledge of breach of any obligation of Lessee under this Lease, shall not be deemed a waiver of such breach. No payment by Lessee or acceptance by Lessor of rent or any payment in a lesser amount than due hereunder shall be deemed to be other than a payment on account, nor shall any endorsement or statement on any check or any letter accompanying any check or payment be deemed an accord and satisfaction, and Lessor may accept such check or payment without prejudice to the right of Lessor to recover the balance or pursue any other remedy against Lessee provided in this Lease or by law.

Section 16. Inability to Perform - If Lessor, by reason of (a) strike, (b) other work stoppage, (c) governmental preemption in connection with a national emergency, (d) any rule, order or regulation of any governmental agency, (e) conditions of supply or demand which are affected by war or other national, state or municipal emergency, or (f) other cause beyond the control of Lessor, shall be unable to fulfill its obligations under this Lease (including, but not limited to, delivery of possession of the Premises) or shall be unable to supply any service which Lessor is obligated to supply to the Lessee or to the Premises, this Lease and Lessor's obligation to pay rent hereunder shall in no wise be affected, impaired or excused except as provided in Sections 10 or 11 hereof, and Lessor shall not be liable to Lessee or to anyone else for damages for or on account of any failure of Lessor to perform because of any such inability.

Section 17. Signage - Signage shall not be installed without Lessor's approval. Such signage shall be installed at Lessee's expense and in accordance with all applicable laws, ordinances, regulations and statutes.

Section 18. Curing Lessee's Defaults - If Lessee shall default in the performance of any obligation under this Lease, Lessor, without thereby waiving such default, may (but shall not be obligated to) perform such obligation for the account and at the expense of Lessee, without notice in a case of emergency, and in any other case if such default continues after the expiration of

   a. ten (10) days from the date Lessor gives Lessee notice of intention to perform such obligation, or

   b. the applicable grace period provided elsewhere in this Lease for cure of such default, whichever occurs later.

All costs, expenses and disbursements of every kind and nature whatsoever incurred by Lessor in connection with any such performance by it for the account of Lessee, including any expenses incurred for any property, material, labor or services provided, furnished or rendered, by Lessor or at its instance, together with any interest thereon, shall be paid by the Lessee to Lessor as additional rent due hereunder promptly upon receipt of an invoice therefore.

Section 19. Events of Default - Each of the following shall constitute an event of default hereunder by Lessee:

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a. the failure by Lessee to pay rent or additional rent to Lessor within ten days after Lessee receives notice thereof from Lessor;

b. the failure by Lessee to perform or observe any other agreement, covenant, term or provision in this Lease binding upon Lessee and the continuation of such failure for a period of thirty (30) days after Lessee receives notice thereof from Lessor, or if such failure cannot be remedied within such thirty (30) day period, the failure of Lessee to commence within such thirty (30) day period and thereafter diligently to prosecute to completion all actions necessary to remedy such failure;

c. the filing by or against Lessee of any bankruptcy, reorganization, insolvency, liquidation, receivership or other similar action or proceeding under any federal or state statute or the institution of an assignment for the benefit of creditors or the inability of Lessee to pay debts as they become due; provided, however, that in the event of an involuntary filing against Lessee of any bankruptcy, reorganization, insolvency, liquidation, receivership or other similar action or proceedings under any federal or state statute, such filing shall not constitute an event of default hereunder if Lessee obtains the dismissal of such action not later than sixty (60) days after the date of filing;

d. the vacating (except in event of casualty) or abandonment of all or any part of the Premises by Lessee, except as expressly permitted hereunder; and

e. the taking or sale of Lessee’s interest in the Premises or in this Lease under any attachment, execution or similar legal process, or any event whereby this Lease or the estate hereby granted or the unexpired term hereof would, by operation of law or otherwise, devolve upon or pass to any party other than Lessee, except as permitted herein.

Section 20. Remedies

a. Lessor, in addition to the remedies given in this Lease or under the law, may do any one or more of the following if Lessee commits a default under Section 20:

(1) end this Lease by giving ten (10) days written notice to the Lessee, and Lessee shall then surrender the Premises to Lessor;

(2) enter and take possession of the Premises either with or without process of law and remove Lessee, with or without having ended the Lease; and

(3) alter locks and other security devices at the Premises.

Lessee waives claims for damages by reason of Lessor’s reentry, repossession, or alteration of locks or other security devices and for damages by reason of any legal process.

b. No Surrender - Lessor’s exercise of any of its remedies or its receipt of Lessee’s keys shall not be considered an acceptance of surrender of the Premises by Lessee. A surrender must be agreed to in a writing signed by both parties.
c. **Rent** - If Lessor ends this Lease or ends Lessee’s right to possess the Premises because of a default under Section 20, Lessor may hold Lessee liable for past due rent, additional rent, and other indebtedness accrued to the date the Lease ends. Lessee shall also be liable for the rent, additional rent and other indebtedness that otherwise would have been payable by Lessee during the remainder of the lease term had there been no default, reduced by any sums Lessor receives by reletting the Premises during the Term.

    d. **Other Expenses** - Lessee shall also be liable for that part of the following sums paid by Lessor and attributable to that part of the Term ended due to Lessee’s default or failure to surrender the Premises as required by this Lease:

        (1) reasonable broker’s fees incurred by Lessor for reletting part or all of the Premises prorated for that part of the reletting term ending concurrently with the then current Term of this Lease;

        (2) the cost of removing and/or storing Lessee’s property;

        (3) the cost of minor repairs, alterations, and remodeling necessary to put the Premises in a condition reasonably acceptable to a new lessee; and

        (4) other necessary and reasonable expenses incurred by Lessor in enforcing its remedies, specifically including attorney’s fees and costs.

    e. **Payment** - Lessee shall pay the sums due in subsections (c) and (d), above, within thirty (30) days of receiving Lessor’s proper and correct invoice for the amounts. During each action to collect Lessor shall be limited to the amount of any sums due under subsection (c) that would have accrued had the Lease not been ended and sums under subsection (d) that have been incurred by Lessor and are now payable by Lessor.

    f. **Mitigation** - Lessor shall mitigate its damage by making reasonable efforts to relet the Premises on reasonable terms. Lessor may relet for a shorter or longer period of time than the lease term and make any necessary repairs or alterations. Lessor may relet on any reasonable terms including a reasonable amount of free rent. If Lessor relets for a period of time longer than the current lease term, then any special concessions given to the new tenant shall be allocated throughout the entire reletting term to not unduly reduce the amount of consideration received by Lessor during the remaining period of the lease term.

**Section 21. Rules and Regulations** - Lessee and the Lessee’s employees, agents and servants shall faithfully observe and comply with the Rules and Regulations attached hereto as Exhibit 2, and such changes therein as Lessor at any time or times hereafter may make and communicate in writing to Lessee. In case of any conflict or inconsistency between the provisions of this Lease and any of such Rules and Regulations as originally promulgated or as changed, the provisions of this Lease shall control. Nothing contained in this Lease shall be construed to impose upon Lessor any duty or obligation to the Lessee to enforce such Rules and Regulations or the terms, covenants or conditions in any other lease, as against any other tenant of the College, and Lessor shall not be liable to Lessee for violation of the same by any other tenant or its employees, agents, servants or
invitees. Lessor shall use reasonable efforts to ensure compliance by all tenants and shall not enforce such rules in a discriminatory manner against Lessee.

Section 22. Subordination

a. Subject to Section 22(b) Lessee agrees that this Lease is and shall be and remain subject and subordinate to all deeds of trust or other Lessor financing, including bonds, which may now or hereafter affect the real property of which the Premises and the University form a part, and to all renewals and extensions thereof. In confirmation of such subordination, Lessee shall execute promptly any instruments of subordination, subject to non-disturbance as set forth in Section 22(b), which Lessor may request. Provided the same do not change, alter, or amend the terms and provisions hereof, and provided Lessee is entitled to non-disturbance as set forth in Section 22(b), Lessee hereby irrevocably constitutes and appoints Lessor as Lessee’s attorney-in-fact to execute any such subordination instruments for and on behalf of Lessee in the event Lessee refuses to execute such instruments.

b. If any financing is foreclosed, then

(1) This Lease shall continue in full force and effect;

(2) Lessee’s quiet possession shall not be disturbed if the Lessee is not in default;

(3) Lessee will attorn to and recognize the mortgagee or purchaser at foreclosure sale (a “Successor Lessor”) as Lessor hereunder for the remaining term.

Section 23. Estoppel Certificates - At any time and from time to time, each party agrees upon request of the other party to execute, acknowledge and deliver to the requesting party a statement in writing certifying that this Lease is unmodified and in full force and effect (or if there have been modifications, that the same is in full force and effect as modified and stating the modifications), the dates to which rent or other charges have been paid, and that the requesting party is not in default, and such other matters pertaining to this Lease as may be requested by the requesting party. The failure of any party to execute and deliver such statement within twenty (20) days after request shall constitute an acknowledgment that such statement and the facts set forth therein are correct.

Section 24. Surrender - Upon the termination of this Lease, or upon any re-entry by Lessor into the Premises, Lessee shall peaceably quit and surrender the Premises to Lessor in good order, condition and repair, except for ordinary wear and tear and such damage or destruction as Lessor is required to repair or restore under this Lease, and Lessee shall remove all of Lessee’s property there from except as otherwise expressly provided in this Lease. In the event that Lessee fails to remove its property following termination of the Lease, Lessor may opt to store the property at Lessee’s expense or retain or dispose of the property without financial obligation to Lessee. The Lessee’s obligation to observe or perform this covenant shall survive the expiration or other termination of this Lease.
Section 25. Holding Over - If Lessee remains in possession of the Premises, or any part thereof, after the termination of this Lease for any reason, whether with or without the consent of Lessor, such possession shall be tenancy at will and in no event shall a tenancy from month to month or from year to year be created or presumed. Such tenancy shall be subject to all the terms and conditions hereof (except as to term) including all rent then payable hereunder, provided that no extension or renewal hereof shall be deemed to have occurred by any holding over.

Section 26. Quiet Enjoyment - Upon payment by Lessee of all rent and any and all other sums to be paid by Lessee to Lessor hereunder and the observance and performance of all the covenants, terms, and conditions to be observed and performed by Lessee, Lessee shall have the peaceable and quiet enjoyment of the Premises, and all rights, servitudes, and privileges belonging, or in any wise appertaining thereto or granted hereby, for the term of this Lease, without disturbance, hindrance or interruption by Lessor, or any other person or persons lawfully claiming by, through, or under Lessor. Lessor warrants that it has full right and authority to enter into this Lease for the full term hereof.

Section 27. Sale of Premises - If Lessor sells or agrees to sell the Premises or any part thereof, Lessee agrees to execute promptly upon request such agreements and certificates and other documents as Lessor reasonably requests in connection therewith; provided, however, that no such agreements or documents shall affect the tenancy created hereunder or the terms and provisions of this Lease.

Section 28. Notices - All notices, demands, requests and other communications hereunder shall be deemed sufficient and properly given if in writing and delivered in person to the following addresses or sent by certified or registered mail, postage prepaid with return receipt requested, or by overnight courier, charges prepaid, at such addresses:

If to the Lessee:  Micah Osborne
President
BSM Technologies
405 N Jefferson Ave
Springfield, MO 65806

If to Lessor:  Matt Morris
Vice President for Administrative Services
Missouri State University
901 South National Avenue
Springfield, MO 65897

Either of the above-mentioned parties may, by like notice, designate any further or different addresses to which subsequent notices shall be sent. Any notice hereunder signed on behalf of the notifying party by a duly authorized attorney at law shall be valid and effective to the same extent as if signed on behalf of such party.
Section 29. Binding Effect - This Lease shall inure to the benefit of, and shall be binding upon, Lessee and Lessor and their respective successors, assigns, heirs and personal representatives.

Section 30. Amendment - This Lease may be amended only by an instrument in writing duly executed by the parties hereto. No amendment shall be effected by any course of conduct or dealing between the parties or by custom or practice.

Section 31. No Remedy Exclusive - No remedy herein conferred upon Lessor is exclusive of any other available remedy or remedies, but each such remedy shall be cumulative and shall be in addition to every other remedy given under this Lease or now or hereafter existing at law or in equity or by statute. No delay or omission to exercise any right or power accruing upon any event of default hereunder by Lessee shall impair any such right or power or shall be construed to be a waiver thereof but any such right or power may be exercised from time to time and as often as may be deemed expedient.

Section 32. No Additional Waiver Implied by One Waiver - In the event any agreement contained in this Lease should be breached by either party and thereafter waived by the other party, such waiver shall be limited to the particular breach so waived and shall not be deemed to waive any other breach hereunder. Further, neither the receipt nor the acceptance of any rent hereunder by Lessor shall be deemed to be a waiver of any breach of any covenant, condition or obligation herein contained or a waiver of any event of default hereunder or a waiver of any remedy available to Lessor.

Section 33. Entire Agreement - This Agreement constitutes the entire agreement, and supersedes all prior agreements and understandings, both written and oral, between the parties with respect to the subject matter hereof.

Section 34. Severability - The provisions of this Lease are severable, and in the event any provision of this Lease shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof.

Section 35. Governing Law - This Lease shall in all respects be governed by and construed in accordance with the laws of the State of Missouri.

Section 36. Miscellaneous - Time is of the essence in the performance of this Lease by Lessee. No partnership or joint venture is established between the parties by the execution hereof or by the use and occupancy of the Premises by Lessee. The section titles and headings are for convenience only and do not define, modify or limit any of the terms and provisions hereof.

Section 37. Lessor's Waiver and Consent - Lessor hereby waives any statutory or common law lien against the personal property of the Lessee. Lessor agrees upon the request of Lessee to execute and deliver and to cause its mortgagees or future mortgagees to execute and deliver a Lessor's Personal Property Waiver and Consent.

Section 38. Sovereign Immunity - Nothing in this Lease Agreement shall be construed to waive any sovereign, official or governmental immunity applicable to either party, their board members,
officers, or employees.

**Section 39. ADA Compliance** - Lessor shall be responsible for assuring that the common areas of the building in which the demised premises are located are in compliance with the requirements of The Americans with Disabilities Act of 1990, and the rules and regulations promulgated thereunder, as such law, rules and regulations may now or hereafter be amended or restated.

**Section 40. Environmental Matters**

a. "Hazardous Materials" as used herein, shall include, but not be limited to:

(1) any waste, material or substance (whether in the form of a liquid, a solid, or a gas, and whether or not air-borne), which is deemed to be a pollutant or a contaminant, or to be hazardous, toxic, ignitable, reactive, corrosive, dangerous, harmful or injurious to public health or to the environment, under the authority of any applicable local, state, or federal laws, judgments, ordinances, orders, rules, regulations, (collectively "Environmental Regulations," and individually, as "Environmental Regulation"), including:

(2) asbestos,

(3) any polychlorinated byphenyl,

(4) any radioactive material, or

(5) any Select Agent or Toxin requiring registration or notification under any federal or state regulations including the Biological Weapons Act and Terrorism Act of 1989, the 1996 Antiterrorism and Effective Death Penalty Act, and the USA Patriot Act of 2001, as amended.

In addition to the foregoing, the term "Environmental Regulations" shall be deemed to include, without limitation, local, state, and federal laws, judgments, ordinances, orders, rules, regulations, codes and other governmental restrictions and requirements, any amendments and successors thereto, replacements thereof and publications promulgated pursuant thereto, which deal with or otherwise in any manner relate to, environmental matters of any kind.

b. Lessee agrees that it shall not cause or knowingly permit any Hazardous Materials to exist on or to escape, seep, leak, spill or be discharged, emitted or released from the Building during the term of this Lease in violation of any applicable law or regulation including any Environmental Regulation.

c. The Parties may but are not required, by subsequent written addendum to this Lease Agreement, agree to permit use in the Building material that would otherwise be prohibited, subject to at least the following conditions: compliance with all applicable laws and regulations are met, including all registration, and establishment of safeguards and handling procedures.

d. Lessee will be responsible for the actual costs incurred to store/remove any tenant-generated chemical/hazardous waste. Such costs will be invoiced to JVIC. Additionally, if the
operation of JVIC results in Lessor becoming a Large Quantity Generator (LQG) or equivalent status, Lessee will be responsible for its pro rata share of additional resulting costs, based on the total amount of waste generated.

Section 41. Self-Help - If Lessee or Lessor shall default in the performance or observance of any agreement, condition or other provision in this Lease and shall not cure such default within thirty (30) days notice in writing from the other party specifying the default (or shall not within said period commence to cure such default and thereafter prosecute the curing of such default to completion with due diligence) the non-defaulting party may (in addition to any other remedy available to the non-defaulting party at law or in equity) at any time thereafter cure such default and the defaulting party shall reimburse the non-defaulting party for any amount paid and any expense or contractual liability so incurred, and any amounts due from Lessee shall be deemed additional rent due and payable with the next installment of monthly rent and any amount due from Lessor may be deducted by Lessee from any rent due hereunder; provided however, that neither may cure any such default as aforesaid prior to the expiration of said cure period but after notice to the other party, if it is necessary to protect the demised premises, or the Building, or to prevent injury or damages to persons or property.

The parties execute this Agreement by their authorized officers, to be legally binding the day and year indicated above, with possession and access provided to Lessee on the Commencement Date as set forth herein.

LESSOR
THE BOARD OF GOVERNORS OF
MISSOURI STATE UNIVERSITY
By ____________________________
Date 8/30/16

LESSEE
ESM
By ____________________________
(name) President
Date 8/8/16
EXHIBIT 1
PREMISES

Buildings 1 & 2 of the Jordan Valley Innovation Center located at the corner of 524 N. Boonville Ave, Springfield, Greene County Missouri, building location of: 6th floor shared lab and office space.
EXHIBIT 2

BUILDING RULES AND REGULATIONS

1. Lessee shall not obstruct or interfere with the rights of other tenants of the Building, or of persons having business in the Building, or in any way injure or annoy such tenants or persons.

2. Lessee shall not occupy the Building or permit any portion of the Building to be occupied for the possession, manufacture or sale of controlled substances in any form. Lessee shall not conduct in or about the Building any auction, public or private, without the prior written approval of Lessor. Lessee shall not use the Building for lodging or sleeping, or for any immoral or illegal purposes or for any purpose that will damage the Building, or the reputation thereof, or for any purposes other than those specified in the Lease.

3. Canvassing, soliciting and peddling in the Building are prohibited, and Lessee shall cooperate to prevent such activities.

4. Lessee shall not bring or keep within the Building any animal, bicycle, or motorcycle.

5. Lessee shall not conduct mechanical or manufacturing operations, cook or prepare food, or place or use any inflammable, combustible, explosive, caustic or hazardous fluid, chemical, device, substance or material in or about the Building without the prior written consent of Lessor. Lessee shall comply with all rules, orders, regulations and requirements of the applicable Fire Rating Bureau, or any other similar body, and Lessee shall not commit any act or permit any object to be brought or kept in the Building which shall increase the rate of fire insurance on the Building or on property located therein.

6. Lessee shall not use the Building for the storage of goods, wares or merchandise, except as such storage may be incidental to the use of the Premises for permitted purposes and except in such portions of the Premises as may be specifically designated by Lessor for such storage.

7. All office equipment and any other device of any electrical or mechanical nature shall be placed by Lessee in the Premises in settings approved by Lessor so, as to absorb or prevent any vibration, noise, or annoyance. Lessee shall not cause improper noises, vibrations or odors within the Building.

8. Lessee shall move all freight, supplies, furniture, fixtures and other personal property into, within and out of the Building only at such times and through such entrances as may be designated by Lessor. Lessor reserves the right to inspect all such freight, supplies, furniture, fixtures and other personal property to be brought into the Building and to exclude from the Building all such objects which violate any of these rules and regulations.
or the provisions of the Lease. Lessee shall not move or install such objects in or about the Building in such a fashion as to unreasonably obstruct the activities of other tenants, and all such moving shall be at the sole expense, risk and responsibility of Lessee. Lessee shall not use in the delivery, receipt or other movement of freight, supplies, furniture, fixtures and other personal property to, from or within the Building, any hand trucks other than those equipped with rubber tires and side guards.

9. Lessee shall not place within the Building any objects of unusual size or weight, nor shall Lessee place within the Building any objects which exceed the floor weight specifications of the Building, without the prior written consent of Lessor.

10. Lessee shall not deposit any trash, refuse, cigarettes, or other substances of any kind within or out of the Building, except in the refuse containers provided therefore. Lessee shall not introduce into the Building any substance which might add an undue burden to the cleaning or maintenance of the Premises or the Building. Lessee shall exercise its best efforts to keep the sidewalks, entrances, passages, courts, lobby areas, garages or parking areas, elevators, escalators, stairways, vestibules, public corridors and halls in and about the Building (Hereinafter “Common Areas”) clean and free from rubbish.

11. Lessee shall use the Common Areas only as a means of ingress and egress, and Lessee shall permit no loitering by any persons upon Common Areas or elsewhere within the Building. The Common Areas and roof of the building are not for the use of the general public, and Lessor shall in all cases retain the right to control or prevent access thereto by all persons whose presence, in the judgment of the Lessor shall be prejudicial to the safety, character, reputation or interests of the Building and its tenants. Lessee shall not enter the mechanical rooms, air conditioning rooms, electrical closets, janitorial closets, or similar areas or go upon the roof of the Building without the prior written consent of Lessor.

12. Lessee shall not use the washrooms, restrooms and plumbing fixtures of the Building, and appurtenances thereto, for any other purpose than the purposes for which they were constructed, and Lessee shall not deposit any sweepings, rubbish, rags or other improper substances therein. Lessee shall not waste water by interfering or tampering with the faucets or otherwise. If Lessee or Lessee’s servants, employees, agents, contractors, jobbers, licensees, invitees, guests, or visitors cause any damage to such washrooms, restrooms, plumbing fixtures or appurtenances, such damage shall be repaired at Lessee’s expense and Lessor shall not be responsible therefore.

13. Lessee shall not manually paint, drill into, cut, string wires within or in any way deface any part of the Building, without the prior written consent of Lessor, and as Lessor may direct. Upon removal of any wall decorations or installations or floor coverings by Lessee, any damage to the walls or floors shall be repaired by Lessor at Lessee’s sole cost and expense. All installations, alterations and additions shall be constructed by Lessee in a good and workmanlike manner and only good grades of materials shall be used in connection therewith.

14. The sashes, sash doors, skylights, windows and doors that reflect or admit light or air into
the Common Areas shall not be covered or obstructed by Lessee through placement of objects upon windowsills or otherwise. Lessee shall cooperate with Lessor in obtaining maximum effectiveness of the cooling system of the Building by closing drapes and other window coverings when the sun's rays fall upon windows of the Premises. Lessee shall not obstruct, alter or in any way impair the efficient operation of Building heating, ventilating, air conditioning, electrical, fire, safety or lighting systems.

15. Subject to the applicable fire or other safety regulations, all doors opening onto Common Areas and all doors upon the perimeter of the Premises shall be kept closed and, during non-business hours, locked, except when in use for ingress or egress. If Lessee uses the Premises after regular business hours or on non-business days Lessee shall lock any entrance doors to the Building or to the Premises used by Lessee immediately after using such doors.

16. All keys to the exterior doors of the Premises shall be obtained by Lessee from Lessor, and Lessee shall pay to Lessor a reasonable deposit determined by Lessor from time to time for such keys. Lessee shall not make duplicate copies of such keys. Lessee shall not install additional locks or bolts of any kind upon any of the doors or windows of, or within, the Building, nor shall Lessee make any changes in existing locks or the mechanisms thereof without consent of Lessor. Lessee shall, upon the termination of its tenancy, provide Lessor with the combinations to all combination locks on safes, safe cabinets and vaults and deliver to Lessor all keys to the Building, the Premises and all interior doors, cabinets, and other key-controlled mechanisms therein, whether or not such keys were furnished to Lessee by Lessor. In the event of the loss of any key furnished to Lessee by Lessor, Lessee shall pay to Lessor the cost of replacing the same or of changing the lock or locks opened by such lost key if Lessor shall deem it necessary to make such a change.

17. Access may be had by Lessee to the Common Areas and to the Premises at any time between the hours of 8:00 A.M. and 6:00 P.M., Monday through Friday, and 8:00 A.M. to Noon on Saturday, legal holidays excepted. At other times access to the Building may be refused unless the person seeking admission is known to the watchman in charge, if any, and/or has a pass or is properly identified. Lessee shall be responsible for all persons for whom Lessee requests passes, and shall be liable to Lessor for all acts of such persons. Lessor shall in no case be liable for damages for the admission or exclusion of any person from the Building. In case of invasion, mob, riot, public excitement, or other commotion, Lessor reserves the right to prevent access to the Building for the safety of Lessees and protection of property in the Building. Should Lessee furnish additional security as set forth in, Lessee's contracted security firm shall notify Lessor's Office of Public Safety of any alerts, and comply with the direction of that Office.

18. Lessor reserves the right to change these rules and to make such other and further reasonable rules and regulations as in its judgment may from time to time be needed for the safety, care and cleanliness of the Building, for the preservation of good order therein or for any other cause, and when so changed or made, such modified or new, rules shall be deemed a part hereof, with the same effect as if written herein, when a copy shall have
been delivered to the Lessee or left with some person in charge of the demised premises.
EXHIBIT 3

The University will arrange for the provision of the following services for Lessee:

- Parking and building access, ice and snow removal, pest control, custodial services including trash disposal, landscaping and lawn care.

- An on-site security guard during daylight hours (8 a.m. to 5 p.m.) and a restricted access system for the main building entry and each floor. When the security guard is not on duty, security will be monitored remotely from the University campus. Periodic roving security patrols will also be provided. If enhanced security is required, additional fees may be assessed.
RECOMMENDED ACTION – Approval of bids and award of a contract for the elevator refurbishing at the Professional Building.

The following resolution was moved by _______________________________ and seconded by ________________________:

BE IT RESOLVED by the Board of Governors for Missouri State University that the low bid of Thyssenkrupp Elevator Corporation in the amount of Ninety-one Thousand Two Hundred Eighty-two and 00/100ths dollars ($91,282.00) for the base bid plus alternate 1 for the elevator refurbishing at the Professional Building be accepted, approved, and awarded.

BE IT FURTHER RESOLVED that the financial plan be established as follows:

<table>
<thead>
<tr>
<th>Project Budget</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Fees</td>
<td>$10,920.00</td>
</tr>
<tr>
<td>Construction Costs</td>
<td>$91,282.00</td>
</tr>
<tr>
<td>Project Administration</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>Construction Contingency</td>
<td>$23,692.30</td>
</tr>
<tr>
<td>Furniture, Fixtures, and Equipment</td>
<td>$6,105.70</td>
</tr>
<tr>
<td>Telecommunications</td>
<td>$0.00</td>
</tr>
<tr>
<td>Relocation Costs</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total Project Budget</strong></td>
<td><strong>$135,000.00</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding Source</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevator Refurbishing Professional Building budget</td>
<td>$135,000.00</td>
</tr>
<tr>
<td><strong>Total Funding Source</strong></td>
<td><strong>$135,000.00</strong></td>
</tr>
</tbody>
</table>

BE IT FURTHER RESOLVED that this be paid from the Elevator Refurbishing Professional Building budget funded from the Maintenance and Repair – Operating budget.

BE IT FURTHER RESOLVED that the Vice President for Administrative Services or the University Architect and Director of Planning, Design & Construction be authorized to sign the agreement with the selected contractor, incorporated herein by reference, and perform those acts necessary to carry out and perform the terms of the agreement. With approval of the above project budget, authorization is also provided to further sign agreements or amendments to existing agreements directly related to this project as long as the approved project budget is not exceeded.

VOTE: AYE________

NAY________

COMMENTS:

The bids received on this project are as follows:
<table>
<thead>
<tr>
<th>Contractor</th>
<th>Base Bid</th>
<th>Alternate 1</th>
<th>Total (Base Bid + Alt. 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyssenkrupp Elevator Corporation</td>
<td>$89,376.00</td>
<td>$1,906.00</td>
<td>$91,282.00</td>
</tr>
<tr>
<td>MEI Total Elevator Solutions</td>
<td>$110,810.00</td>
<td>$3,200.00</td>
<td>$114,010.00</td>
</tr>
<tr>
<td>Kone, Inc.</td>
<td>$118,670.00</td>
<td>$925.00</td>
<td>$119,595.00</td>
</tr>
</tbody>
</table>

This project will include the renovation of the south elevator in the Professional Building. The elevator is presently out of service and cannot be repaired due to the obsolescence of the controller. The project will include replacement of components and the controller to bring the elevator back to a state of reliable operation. The work is scheduled to be completed during the 2018 spring semester.

The construction contingency is larger than normal due to electrical and fire alarm work that may need to occur once the current elevator components are removed and exposed.

This project will be paid from the Elevator Refurbishing Professional Building budget funded from the Maintenance and Repair – Operating ($135,000.00) budget.
VII.A.

RECOMMENDED ACTION - Approval of Missouri State University Group Medical Plan.

The following resolution was moved by ________________________ and seconded by ________________________:

WHEREAS, Med-Pay, the Third Party Administrator of the Missouri State University Group Medical and Dental Plans, has recommended that, in order to bring the plan into conformance with industry standards and best medical practices the plan should be restated;

WHEREAS, in an effort to streamline processes, Administration recommends changing the effective date of coverage for active staff employees and retirees to mirror the current faculty effective dates, and changing the termination dates for non-faculty coverage to also mirror that of the faculty;

WHEREAS, certain revisions to the Plan are necessary to keep it competitive, legally compliant and responsive to employee needs;

WHEREAS, as a result of the proposed revisions to the Medical Plan, similar revisions to the Dental Plan, Faculty Handbook, Employee Handbook and/or other group insurance agreements may be required in order to ensure consistency and accuracy across these documents.

WHEREAS, the Administration recommends that the restated Medical Plan be approved, with an effective date of January 1, 2018.

NOW, THEREFORE, BE IT RESOLVED by the Board of Governors for Missouri State University that the Medical Plan be restated and revised to include effective date changes and exclusions and make minor changes and clarifications, effective as of January 1, 2018; and that the Dental Plan, Employee Handbook, and Faculty Handbook be revised as necessary to ensure consistency between said documents; and that the President and the Vice President for Administrative Services be granted both the authority to correct any typographical errors appearing from time to time to retain accuracy and consistency, and the authority to revise other University procedures and plan documents to allow the application of the above medical plan changes and to ensure compliance with applicable law.

VOTE: Aye ___
Nay ___

COMMENTS:

Med-Pay, the Third Party Administrator of the University's Group Medical and Dental Plans, has indicated that the current Medical Plan does not reflect current medical language and industry standards. To bring the Medical Plan into conformance with industry norms, Med-Pay recommends that the Medical Plan be restated and revised as indicated in the attached Group Medical Plan effective January 1, 2018.
The proposed substantive changes to the Medical Plan are summarized below:

**Eligible Classes of Dependents**
- Administration recommends amending the plan in order to exclude from coverage eligibility employee children who are over the age of 26, but who were adjudicated disabled prior to turning 26. This recommended amendment is legally permissible, has already been implemented in many health plans nationwide, and would help limit and manage future financial costs associated with the University’s health plan.

**Effective Date for Coverage of Active Employees**
- Effective Date for Coverage of Active Employees changed to mirror the current faculty language.
  - The first of the month following the date of employment or the date of employment if it is the first business day of the month.

**Effective Date of Retiree Coverage**
- Effective Date of Retiree Coverage changed to mirror the current faculty language.
  - First of the month following retirement.

**Termination of Coverage**
- New language combines Faculty and Non-faculty into one paragraph
  - The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes termination of Active Employment of the covered Active Employee.

**Effective Date and Publication:**
- The restatement effective date of the Missouri State University Group Medical Plan should be January 1, 2018.
- The restated Medical Plan will be published and distributed.
PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
MISSOURI STATE UNIVERSITY
GROUP MEDICAL PLAN

Group Number GROUP NUMBER 090188SMSU

EFFECTIVE JANUARY 1, 2018
INCLUDES AMENDMENTS 1-3 AS OF JANUARY 1, 2016
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INTRODUCTION

Today's high cost of medical care has made comprehensive health care coverage essential. The Missouri State University Group Medical Plan has been designed to protect Employees against catastrophic financial loss due to illness or accident. While there are some areas of the Plan which require Employees to share in health care costs, there are also allowances for 100% (first dollar) coverage. These 100% benefits are designed to encourage Employees to seek the most cost-effective method of health care.

Missouri State University, hereinafter referred to in this document as the “University” hereby establishes the benefits, rights, and privileges which shall pertain to participating employees, retirees, and eligible dependents, as defined herein, and who shall be referred to as “Covered Persons”, and which benefits are provided as established by this Plan Document for the Group Medical Plan, hereinafter referred to as the “Plan.”

This booklet serves as the official Plan Document and is used by the claims supervisor, Med-Pay, Inc., to pay claims. No oral interpretations can change this Plan. This booklet takes the place of any other booklet or communication issued to you on a prior date describing benefit coverage. While the University hopes to continue the Plan indefinitely, it has the right to amend, suspend, discontinue or terminate the Plan at any time and for any reason.

The Plan is a contributory, self-funded medical plan. That is, the University and Employees, Retirees, and COBRA Continuants provide the funds with which benefit payments are made. Med-Pay, Inc., a third party administrator, processes employee medical claims and payments for the University.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

The Plan believes that it is a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of Health Care Reform that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under Health Care Reform such as the elimination of lifetime limits on benefits. This Plan does offer some benefits without cost sharing.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in this document.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:
**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Medical and Prescription Benefits.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

> This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are not covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

**Responsibilities for Plan Administration.** Explains the responsibilities for the Plan Administrator and includes information about the Plan's obligations with respect to Participants' privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) and the Plan's compliance with the HIPAA Electronic Security Standards. Explains the Plan's structure and the Participants' ERISA (Employee Retirement Income Security Act) rights under the Plan.

**HIPAA Privacy.** Explains the Plan's obligations with respect to Participants' privacy rights under the Health Insurance Portability and Accountability Act (HIPAA).

**HIPAA Security.** Explains the Plan's compliance with the Health Insurance Portability and Accountability Act (HIPAA) Electronic Security Standards.
SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBILITY: Contact the Claims Supervisor to verify eligibility for Plan benefits before the charge is incurred. (Refer to General Plan Information section for contact information.)

PREADMISSION CERTIFICATION (also referred to as PRECERTIFICATION) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Utilization Review Coordinator will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to an In-Network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

PRECERTIFICATION REQUIREMENT: If any part of a Hospital or other Inpatient stay is not precertified per the instructions in the Cost Management Section, the benefit payment will be reduced by $200. A $100 penalty will be assessed for each unauthorized day of a precertified Inpatient stay.

The Plan may not, under state or Federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean delivery. (The Hospital stay begins at the time of delivery, or admission if the delivery occurred outside the Hospital.) The attending Physician does not have to obtain precertification from the Plan; however the Covered Person is still required to precertify the Hospital stay to avoid the above precertification penalty. (Refer to the Cost Management Services Section and Medical Benefits Section for complete details.)

PREAUTHORIZATION of certain services is requested and may expedite the adjudication of the claim. (For items marked with "**" in the table, refer to the Cost Management Services Section for complete details.) Transplants: All Organ Transplant services, including evaluation, must be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator (Refer to General Plan Information section for contact information) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization.

TIMELY FILING OF CLAIMS: Claims must be filed with the Claims Supervisor within 365 days of the date charges for the services were incurred. If the Covered Person’s coverage terminates, all claims must be filed within 90 days of the Covered Person’s termination date. If the termination is due to death, the regular filing limit applies. If the Plan should terminate, all claims must be filed within 30 days of the Plan’s termination date. Benefits are based on the Plan’s provisions at the time the charges were incurred. Claims filed later than that date may be declined. (Refer to the section entitled "How to Submit a Claim").

MEDICAL BENEFITS

To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria:

1. Medically Necessary;
2. Ordered by an appropriate Physician;
3. Not excluded under the Plan; and

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the above. Charges will be allowed at the Usual and Customary Allowance, contracted rate, negotiated or billed amount, whichever is less unless specifically stated otherwise in the contract with that provider or elsewhere in this Plan. Notwithstanding these allowances, all charges from all providers will be subject to a review for Reasonable allowance.

The meanings of these capitalized terms are in the Defined Terms section of this document.

CALCULATION OF THE ALLOWED AMOUNT UNDER THIS PLAN

Charges will be allowed at the Usual and Customary Allowance, Participating Provider Organization (PPO) contracted rate, negotiated rate or billed amount, whichever is less or according to the contract with the Network Provider unless specifically stated elsewhere in this Plan. Notwithstanding these allowances, all charges from all providers will be subject to a review for Reasonable allowance and never be allowed at a rate greater than billed charges.
The Plan is a plan which contains multiple Participating Provider Organizations.

Regional PPO for Southwest Missouri: Mercy Health Network
Telephone: (417) 820-9868 or if calling from outside the Springfield Missouri area (866) 732-4453
Web site: http://mercyoptions.net

National Wrap PPO, for outside the above area: First Health Network
Telephone: 800-226-5116
Web site: www.firsthealth.com

Note: The utilization of this network is not required. Refer to the exceptions listed below for when the higher Participating-Network Provider benefit is applied to services rendered by Non-Network Participating Providers.

Taylor Health Center and Other On-Campus Academic Clinical Facilities: Eligible expenses incurred by Plan members who utilize the University’s on-campus Taylor Health and Wellness Center and academic clinical facilities will be processed under the percentages delineated in the Schedule of Benefits for Participating Network Providers. Plan members for whom this Plan is their primary insurance coverage, must assign Plan benefits for unpaid balances to be paid to Taylor Health Center.

Other Contracted Providers: The Claims Administrator may also contract directly with certain Hospitals and Physicians. These providers will be considered Participating-Network Providers.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Network Providers. Because these Participating Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Participating Network Provider is used. It is the Covered Person’s choice as to which Provider to use. Network Providers are qualified medical professionals, however neither the Plan nor the network is responsible for damages caused by provider acts or failures to act. Accordingly, Covered Persons will have free choice of any legally qualified Physician or Other Professional Provider and the doctor/patient relationship will be maintained with any provider chosen.

Additional information about this network is available at the Human Resources office. A list of Participating-Network Providers is available by calling the PPO or searching for a provider on the PPO’s web site. The phone number and web site are listed above and on your health care plan ID card. In order to obtain benefits at the higher level, it is the Covered Person’s responsibility to make sure the provider is participating in the network prior to seeking services. Call the PPO to verify the current status of the provider before each visit.

Services, as used in this Plan document, means a recognized or standard medical service; it does not mean a specific technique, procedure, or equipment. For example, hip replacement surgery would be considered a recognized or standard medical service; however, the specific technique used by the Physician, i.e., the manner of performing the surgery, is not considered as a service such as to qualify the Covered Person for an exception to the Non-network reimbursement percentage.

Under the following circumstances, the higher Participating-Network benefit will be applied for certain Non-ParticipatingNetwork Provider services:

FOR COVERED PERSONS RESIDING WITHIN THE REGIONAL PPO NETWORK AREA:

- WHEN SERVICES ARE RENDERED OUTSIDE THE NETWORK AREA it may be possible to receive the higher benefit:
  - If a Covered Person requires services Incidental in nature. A referral is not required. The national PPO network is available but utilization of the network is not mandatory.
  - If a Covered Person has an Emergency Medical Condition (on an inpatient or outpatient basis) that is a Life-threatening situation when the Covered Person had no control regarding the
Hospital to which they were taken. This applies to ambulance transport, facility and Physician charges. For an Inpatient admission, in order to continue to receive the higher benefit once the Covered Person’s condition has been stabilized following admission to a Non-ParticipatingNetwork facility, the Covered Person must be transferred to a ParticipatingNetwork facility.

- If a Covered Person has no choice of a regional PPO ParticipatingNetwork Providers in the specialty required to treat the Illness or Injury. A referral is not required. Verification of the availability, or lack thereof, of a ParticipatingNetwork Provider must be submitted to the Utilization Review Coordinator by the Covered Person or the Physician to review for authorization of payment at the ParticipatingNetwork Provider benefit level prior to seeking services.

- If a Covered Person is seeking services by a Non-ParticipatingNetwork Provider when the services are available in the network area by a ParticipatingNetwork Provider, prior to seeking services, the ParticipatingNetwork Provider in that specialty must submit a referral to the Utilization Review Coordinator to determine if the services will be considered under the ParticipatingNetwork Provider benefit and the time period for which the services will be approved under this exception. A referral is required even if the provider being referred to is in the Mercy extended PPO coverage area outside Southwest Missouri.

- If a Covered Person is admitted to a ParticipatingNetwork Provider facility on an Inpatient or Outpatient basis and receives Physician, diagnostic or anesthesia services by a Non-ParticipatingNetwork Provider when a ParticipatingNetwork Provider in that specialty is not available.

- If a Covered Person has a specimen for a lab test drawn or an x-ray taken by a ParticipatingNetwork Provider but a Non-ParticipatingNetwork Provider performs the lab test or reads the x-ray.

- If a Covered Person receives treatment, services or supplies by a Non-ParticipatingNetwork Provider and the charges for the services were negotiated and/or approved by the Utilization Review Coordinator (refer to General Plan Information section for contact information. Precertification is not an approval of the services or a guarantee of payment for the services.)

**WHEN SERVICES ARE RENDERED WITHIN THE NETWORK AREA it may be possible to receive the higher benefit:**

- If a Covered Person has no choice of a regional PPO ParticipatingNetwork Providers in the specialty required to treat the Illness or Injury. A referral is not required. The national PPO network is available but utilization of the network is not mandatory. Verification of the availability, or lack thereof, of a ParticipatingNetwork Provider must be submitted to the Utilization Review Coordinator by the Covered Person or the Physician to review for authorization of payment at the ParticipatingNetwork Provider benefit level prior to seeking services.

- If a Covered Person is seeking services by a Non-ParticipatingNetwork Provider when the services are available by a ParticipatingNetwork Provider. Prior to seeking services, the ParticipatingNetwork Provider in that specialty must submit a referral to the Utilization Review Coordinator to determine if the services will be considered under the ParticipatingNetwork Provider benefit and the time period for which the services will be approved under this exception.

- If a Covered Person has an Emergency Medical Condition (on an Inpatient or Outpatient basis) that is a Life-threatening situation when the Covered Person had no control regarding the Hospital to which they were taken. This applies to ambulance transport, facility and Physician charges. For an Inpatient admission, in order to continue to receive the higher benefit once the Covered Person’s condition has been stabilized following admission to a Non-ParticipatingNetwork facility, the Covered Person must be transferred to a ParticipatingNetwork facility.
FOR COVERED PERSONS RESIDING OUTSIDE THE REGIONAL PPO NETWORK AREA:

- WHEN SERVICES ARE RENDERED OUTSIDE THE REGIONAL NETWORK AREA, the Covered Person will receive the higher benefit:
  - A referral is not required. The national PPO network is available but utilization of the network is not mandatory.

**NOTE:** Charges for services with discounts accessed through a repricing network in absence of any other exception listed above will be considered at the Non-ParticipatingNetwork Provider benefit level.

Deductibles payable by Covered Persons

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that the Covered Person must pay once a Calendar Year before the Plan pays on any incurred Covered Charges. Beginning in January of each year, the deductible must again be met before Plan benefits are paid. Some services may have the deductible waived. Refer to the Schedule of Benefits for details.
SCHEDULE OF BENEFITS - MEDICAL

(Refer to Medical Benefits Section for further details on each item listed.)
(Refer to the Cost Management Services Section for preauthorization on items marked with “*”.)

<table>
<thead>
<tr>
<th>LIFETIME MAXIMUM</th>
<th>TAYLOR HEALTH CENTER &amp; OTHER ON-CAMPUS CLINICAL FACILITIES</th>
<th>PARTICIPATING NETWORK PROVIDERS</th>
<th>NON-PARTICIPATING NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: The maximums listed below are the total for Participating Network and Non-Participating Network Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating Network and Non-Participating Network Providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEDUCTIBLE, PER CALENDAR YEAR**

<table>
<thead>
<tr>
<th>Per Covered Person</th>
<th>Deductible Waived</th>
<th>$800</th>
<th>$1,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Family Unit</td>
<td>Deductible Waived</td>
<td>$1,600</td>
<td>$3,200</td>
</tr>
</tbody>
</table>

The Calendar Year deductible is waived for the following Covered Charges:
- Charges incurred at Taylor Health and Wellness Center and other on-campus clinical facilities
- Second Surgical Opinion, Voluntary
- Childhood immunizations (for covered children through age 5)

**MAXIMUM COINSURANCE AMOUNT, PER CALENDAR YEAR**

<table>
<thead>
<tr>
<th>Per Covered Person</th>
<th>$2,000</th>
<th>$2,000</th>
<th>$4,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Family Unit</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

The following charges do not apply toward the coinsurance maximum and are never paid at 100%:
- Deductible(s)
- Cost containment penalties
- Prescription copayments
- Amounts over Usual and Customary Allowance

**MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR**

<table>
<thead>
<tr>
<th>Per Covered Person</th>
<th>$2,000</th>
<th>$2,800</th>
<th>$5,600**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Family Unit</td>
<td>$4,000</td>
<td>$5,600</td>
<td>$11,200**</td>
</tr>
</tbody>
</table>

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

** When a Non-Network Provider is utilized, the Covered Person is responsible for any amounts over the Usual and Customary Allowance without this amount being applied toward the Maximum Out-of-Pocket amount. Therefore, the total actual amount the Covered Person may be responsible to pay may be greater than the amount listed.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:
- Cost containment penalties
- Prescription copayments
- Amounts over Usual and Customary Allowance.

Note: The maximum amounts an individual can contribute to the in-network deductible and coinsurance family maximums are amounts up to the in-network “Per Covered Person” maximums. Therefore, if the individual has out-of-network services, only the amount up to the in-network maximum will be counted toward reaching the family’s in-network maximum. For example, an individual has Out-of-Network Covered Charges of $2,200. $1,600 will be applied to the Out-of-Network deductible. The individual In-Network deductible amount will be credited $800 for calculating their In-Network deductible and the family unit maximum.

**COVERED CHARGES**

<table>
<thead>
<tr>
<th>Ambulance Service</th>
<th>Emergency Medical Condition</th>
<th>Not applicable.</th>
<th>80% after deductible</th>
<th>60% after deductible (See when exceptions apply.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Non-emergency (if eligible)</td>
<td></td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

*Applied Behavior Analysis for Autism Spectrum Disorders

<table>
<thead>
<tr>
<th>Not applicable.</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
</table>

Note: *This benefit is for Dependent Children up to age 19. Refer to the Medical Benefit section for further details of this benefit.*
<table>
<thead>
<tr>
<th>Service</th>
<th>TAYLOR HEALTH CENTER &amp; OTHER ON-CAMPUS CLINICAL FACILITIES</th>
<th>PARTICIPATING NETWORK PROVIDERS</th>
<th>NON-PARTICIPATING NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Cardiac/Pulmonary Rehabilitation</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Contact lenses or glasses</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Note: When required following eye surgery, except surgeries to correct refractive disorders. Refer to the Medical Benefit section for further details of this benefit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Note: Includes X-rays, laboratory test, audiology tests, Pre-Admission Testing and screening colonoscopies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Durable Medical Equipment</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible (See when exceptions apply.)</td>
</tr>
<tr>
<td>Emergency Medical Condition</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Medical Non-Emergency Care</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>*Home Health Care</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>(Immediate family only)</td>
<td>40 visits Calendar Year maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Jaw Joint/TMJ</td>
<td>Excluded under Medical Plan. Refer to Dental Benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Hospital Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Newborn Nursery Care</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Note: Well Newborn charges will be considered under the benefits of the covered newborn.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Other Outpatient Services not listed herein</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>*Mental Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient and office visits</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>*Occupational Therapy</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Non-Designated Transplant Facility:</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Designated Transplant Facility:</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Jaw Joint/TMJ</td>
<td>Excluded under Medical Plan. Refer to Dental Benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Organ Transplants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient and office visits</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>*Orthotics</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>*Outpatient Private Duty Nursing</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>*Physical Therapy</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>*Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient visits:</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Newborn Physician Care (Inpatient)</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office visits:</td>
<td>80%, deductible waiveab</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>All other services in the Physician's office:</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Note: Dependent daughters not covered. Two ultrasounds will be considered eligible expenses for a routine Pregnancy for the following: to determine gestational age and for routine screening.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs (Inpatient, Outpatient &amp; Physician's office)</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Well Adult Care</td>
<td>100%, deductible waived</td>
<td>80%, deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>TAYLOR HEALTH CENTER &amp; OTHER ON-CAMPUS CLINICAL FACILITIES</strong></td>
<td><strong>PARTICIPATING NETWORK PROVIDERS</strong></td>
<td><strong>NON-PARTICIPATING NETWORK PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>for the first $400 in allowed charges.</td>
<td>waived for the first $400 in allowed charges.</td>
<td>The first $400 in allowed charges each Calendar Year will be counted toward this benefit in case services are provided by both Participating Network and Non-Participating Network Providers.</td>
<td></td>
</tr>
<tr>
<td>Thereafter, 80% with the deductible waived.</td>
<td>Thereafter, 80% after deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>West Plains campus Employees/Covered Dependents:</strong></td>
<td><strong>West Plains campus Employees/Covered Dependents:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%, deductible waived for the first $400 in allowed charges.</td>
<td>100%, deductible waived for the first $400 in allowed charges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thereafter, 80% after deductible.</td>
<td>Thereafter, 80% after deductible.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Benefit restricted to services performed in conjunction with category “Routine” diagnosis codes in the current ICD book or are preventive/screening services. For example, office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, urinalysis, other cancer screenings and immunizations. Immunizations administered to prevent diseases such as yellow fever, typhoid, malaria, etc. in order to travel outside the United States (whether elective travel or for work-related travel) will be considered under this benefit. (Refer to Diagnostic Testing for coverage of screening colonoscopies.)

Also included in this benefit are **breast pumps**. Refer to Medical Benefits, Routine Well Adult Care for coverage criteria. The **allowed amount** for the purchase through a Non-Participating Network Provider will be no greater than $300.

**Frequency limits for mammogram**
- Ages 35 through 39 ................................................................. single Baseline mammogram
- Ages 40 and over ................................................................. annually

**Routine Well Child Care**
- 100%, deductible waived for the first $400 in allowed charges.  
  Thereafter, 80% with the deductible waived.
- 80%, deductible waived for the first $400 in allowed charges.
  Thereafter, 80% after deductible.

**West Plains campus Employees/Covered Dependents:**
- 100%, deductible waived for the first $400 in allowed charges.
  Thereafter, 80% after deductible.

**West Plains campus Employees/Covered Dependents:**
- 100%, deductible waived for the first $400 in allowed charges.
  Thereafter, 80% after deductible.
<table>
<thead>
<tr>
<th>TAYLOR HEALTH CENTER &amp; OTHER ON-CAMPUS CLINICAL FACILITIES</th>
<th>PARTICIPATING NETWORK PROVIDERS</th>
<th>NON-PARTICIPATING NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations through age 5</td>
<td>100%, deductible waived</td>
<td>100%, deductible waived</td>
</tr>
<tr>
<td>Note: This benefit applies to poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diptheria, hepatitis B, Haemophilus influenza type H (HIB) and varicella, and other immunizations as required by law. Contact your local Health Department to inquire about free immunizations. Waiver of deductible and payment of 100% only applies to the immunization and administration charge. All other services are subject to the Routine benefit listed in this section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Prosthetics</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Second Surgical Opinion, Voluntary</td>
<td>80%, deductible waived</td>
<td>100%, deductible waived</td>
</tr>
<tr>
<td>Note: Refer to Cost Management Services section. Benefits for a second opinion for non-surgical services requires Utilization Review Coordinator approval.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>*Speech &amp; Audiologist Therapy</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Note: All services rendered by a chiropractor are subject to these maximums.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Inpatient</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient and office visits</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Teeth (replacement of)</td>
<td>Not applicable.</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Note: This benefit is for the replacement of teeth removed for the medical management of a hazardous medical condition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapies</td>
<td>*Cardiac Rehabilitation</td>
<td>80%, deductible waived</td>
</tr>
<tr>
<td></td>
<td>*Occupational Therapy</td>
<td>Not applicable.</td>
</tr>
<tr>
<td></td>
<td>*Physical Therapy</td>
<td>80%, deductible waived</td>
</tr>
<tr>
<td></td>
<td>*Pulmonary Rehabilitation</td>
<td>80%, deductible waived</td>
</tr>
<tr>
<td></td>
<td>*Speech &amp; Audiologist Therapy</td>
<td>80%, deductible waived</td>
</tr>
<tr>
<td></td>
<td>Vision Therapy</td>
<td>80%, deductible waived</td>
</tr>
<tr>
<td>Tobacco Use Cessation Programs</td>
<td>100%, deductible waived</td>
<td>80%, deductible waived</td>
</tr>
<tr>
<td></td>
<td>West Plains campus Employees/Covered Dependents:</td>
<td>100%, deductible waived</td>
</tr>
<tr>
<td></td>
<td>$350 Allowed per Calendar Year. Not covered thereafter.</td>
<td>$350 Allowed per Calendar Year. Not covered thereafter.</td>
</tr>
<tr>
<td></td>
<td>$350 Allowed per Calendar Year. Not covered thereafter.</td>
<td>$350 Allowed per Calendar Year. Not covered thereafter.</td>
</tr>
<tr>
<td>Note: 1) Benefits allowed include: office visit with a trained/certified therapist, counselor, healthcare provider, or Physician and treatments. 2) The cost for prescription medicines to treat tobacco use will be applied to the Prescription Drug Benefit and will not count towards the annual allowable amount listed above. 3) Over-the-counter nicotine replacement therapies, as part of a tobacco cessation program, will only be eligible for benefits if they are obtained with a prescription; the costs will be applied as stated in the Prescription Drug Benefit Schedule.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Weight Management (Obesity Treatment)</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Wigs</td>
<td>Not applicable.</td>
<td>80% after in-network deductible</td>
</tr>
<tr>
<td>Note: Refer to Medical Benefits section for coverage criteria.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other Covered Charges not excluded or limited in this Plan Document:</td>
<td>80%, deductible waived</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>
(Refer to the Cost Management Services Section for preauthorization on items marked with "*".)
## SCHEDULE OF BENEFITS

### PRESCRIPTION DRUGS

**PRESCRIPTION DRUG BENEFIT**

All prescriptions should be filed through the Pharmacy Benefit Manager (PBM).

<table>
<thead>
<tr>
<th></th>
<th>TAYLOR HEALTH PHARMACY</th>
<th>PARTICIPATING NETWORK PHARMACY</th>
<th>NON-PARTICIPATING NETWORK PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Covered Person</td>
<td>$1,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Family Unit</td>
<td>$3,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Generic Incentive:**

Covered Expenses will be limited to the cost of a Generic drug if an equivalent Generic drug is available when a Multi-source Brand Name drug is dispensed. In addition to the coinsurance, the Covered Person must pay the difference between the cost of the Generic drug and the Multi-source Brand Name drug.

**Retail Prescriptions- (Per 30-day supply)**

<table>
<thead>
<tr>
<th></th>
<th>Generic Drugs</th>
<th>Brand Name Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

(See Note below.)*

**Mail Order or Participating Network MedTrak 90 Pharmacy Option- (Per 90-day supply)**

<table>
<thead>
<tr>
<th></th>
<th>Generic Drugs</th>
<th>Brand Name Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

(See Note below.)*

Prior authorization is required for any prescription over $1,000 (30-day) or $2,000 (90-day).

**Specialty Drugs** treat multi-faceted chronic diseases. They typically require unique clinical, administration, distribution and handling requirements. They are more expensive than traditional prescriptions and there are limited generics and biosimilars available. Biosimilars are a potential future opportunity that will provide therapeutic options for already approved specialty brand drugs at potentially lower costs. A list of these drugs is available by contacting the Claims Supervisor or Pharmacy Benefit Manager as stated on your health plan ID card. Only available through network specialty Pharmacy or retail location.

**Filing for a Prescription Drug Benefit reimbursement when a Non-Participating Network Pharmacy is used or when the Pharmacy Card is not used:**

*If this is your primary plan,* all prescriptions should be filed through the Pharmacy Benefit Manager (PBM). If the Pharmacy charges less than the discount price available through the PBM, you may purchase the prescription without the card and submit the receipt along with a claim form to the PBM and state the situation on the form.

The reimbursement (based upon the PBM allowance less a small processing fee) will be sent to the Covered Employee. Some exceptions to the PBM allowance may be made for extenuating circumstances. Typically, a Pharmacy can refile a claim within 14 days if a problem existed in filing the claim electronically. The PBM help desk is available six days a week to assist the Pharmacy with rejected claims.

*If this is your secondary plan,* submit your receipt and/or explanation of benefits from your primary plan to Med-Pay. The coordination of benefits provision applies and benefits are payable under this Prescription Plan. The billed amount will be the amount listed on the receipt (total amount allowed or copayment, if total allowed is not listed). This Plan will pay prescription drug benefits as primary for any Active Employee who is also Medicare eligible.

Contact the PBM (see your ID card) for any questions about what drugs are covered under this Plan.

Claim forms may be obtained on the Missouri State University website.
ELIGIBILITY

Eligible Classes of Participants. The following classes of Participants are eligible for coverage under the Plan:

1. All full-time Active Employees on regular appointment.

2. All Retired Employees of the University. Provided such employees are eligible for and receiving a retirement pension from the University's public retirement plan; and who have maintained continuous coverage under the University's Group Medical Insurance Plan immediately prior to retirement; and are not eligible for Medicare.

3. The Surviving Spouse or Sponsored Dependent of an Active Employee. Providing at the time of death the employee was a full time active employee; the employee had elected insurance coverage which included the spouse; the employee was eligible for but not yet receiving a retirement pension from one of the University's public retirement plans; and the Surviving Spouse is not eligible for Medicare.

4. The Surviving Spouse or Sponsored Dependent of a Retired Employee. Providing at the time of death the retired employee had elected insurance coverage which included the Spouse or Sponsored Dependent; and had maintained continuous coverage under the University’s Group Medical Insurance Plan; and was receiving a retirement pension from the University’s public retirement plan; and the Surviving Spouse or Sponsored Dependent is not eligible for Medicare. An eligible Surviving Spouse or Sponsored Dependent of a Retired Employee who subsequently remarries, may continue the coverage in effect under the University's Group Medical Insurance Plan prior to the remarriage provided such Surviving Spouse or Sponsored Dependent continues to receive a retirement pension from one of the University’s public retirement plans.

Eligibility Requirements for Participant Coverage. A person is eligible for Participant coverage from the first day that he or she satisfies one of the following: (Refer to the EFFECTIVE DATE section for when coverage commences.)

1. New Employee

   (a) Non-variable Hour Employee

      (i) is a Full-time, Active Employee of the Employer (has begun working for the Employer). An Employee is considered to be Full-time if he or she works:

      1. on regular appointment (faculty and non-faculty) with the University for that work; or

      2. works at least 30 Hours of Service per week and is on the regular payroll of the Employer for that work.

      (ii) is in a class eligible for coverage.

      (iii) Coverage will be afforded according to the "Effective Date" of Active Employee coverage.

   (b) Variable Hour Employee, Part-time Employee or Seasonal Employee

      (i) based on Hours of Service during the Initial Measurement Period, has been determined, during the New Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she averaged 30 or more Hours of Service per week (130 Hours of Service or more in a month) during the Initial Measurement Period. **Coverage will be effective on the first day of the New Employee Stability Period, subject to completion of enrollment requirements. The Employee will remain eligible throughout the New Employee Stability Period to the extent that the Employee remains employed, subject to the Plan's Break in Service Rules.**

      (ii) is in a class eligible for coverage.
Variable Hour Employee, Part-time Employee or Seasonal Employee experiencing a change in employment status to Full-time

(i) is in a class eligible for coverage.

(ii) Coverage will be afforded according to the “Effective Date” of Active Employee coverage.

(2) Ongoing Employee

(a) based on Hours of Service during the Standard Measurement Period, has been determined, during the Ongoing Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she averaged 30 or more Hours of Services per week (130 Hours of Service or more in a month) during the Standard Measurement Period. The Employee will remain eligible for coverage during the Plan’s next Ongoing Employee Stability Period, provided that the Ongoing Employee remains employed, and subject to the Plan’s Break in Service Rules. Coverage will be effective on the first day of the Ongoing Employee Stability Period, subject to completion of the enrollment requirements.

(b) is in a class eligible for coverage.

(3) Ongoing Employee experiencing a change in employment status from non-Full-time to Full-time Employee during the Ongoing Employee Stability Period

(a) is a Full-Time, Active Employee of the Employer (has begun working for the Employer). An Employee is considered to be Full-time if he or she works at least 30 Hours of Service per week and is on the regular payroll of the Employer for that work.

(b) is in a class eligible for coverage.

(c) Coverage will be afforded according to the “Effective Date” of Active Employee coverage

(4) Retired Employee of the Employer

Capitalized terms used above that are not included in the Defined Terms section of the Plan Document can be found in the Plan’s Eligibility Appendix.

Note: Coverage under this Plan is available to Employees age sixty-five (65) and over and to Spouses age sixty-five (65) and over of Employees under the same conditions as coverage is available to Employees and their Spouses under age sixty-five (65). Nonetheless, Employees over age sixty-five (65) are entitled to select primary coverage under Medicare. To do so, they must decline all coverage under this Plan.

If coverage under the Plan lapses because the Employee, Spouse elects to decline coverage after reaching age sixty-five (65), they may become covered again only by filling out a request for reinstatement with the Plan Administrator. For Dependents, the Employee must successfully re-enroll as well. All other Plan provisions will apply, e.g., open enrollment, etc.

Eligible Classes of Dependents. The Plan Administrator may from time to time require documentation to substantiate eligibility. To be eligible under the Plan as a dependent of a Retired Employee, a person must have been covered as a dependent of the Retired Employee while the Retired Employee had coverage as an Active Employee. A Dependent is any one of the following persons:

(1) Spouse of a covered Active Employee or Retired Employee.

The term "Spouse" shall mean the person recognized as the covered Active or Retired Employee’s husband or wife legally married in one of the 50 states of the United States.

The Spouse of a Retired Employee who has been covered under the Plan may continue to be covered under the Plan even though the Retired Employee is not eligible for coverage under the Plan due to the Retired Employee becoming eligible for Medicare Part A and/or enrolled in other Medicare plans. Such Spouse may continue to be covered under the Plan until he/she becomes eligible for Medicare Part A.

The Plan Administrator may require documentation proving a legal marital relationship. Proof of marriage is established by one of the following:
(2) Sponsored Adult Dependent

The term "sponsored dependent" or "sponsored adult dependent" shall mean an individual: (1) at least 18 years old and mentally competent; (2) have shared the same residence with a full-time employee for at least 12 months and continue to share a residence; (3) not legally married to anyone else in any state; (4) not be related by blood to a degree of closeness that would prohibit legal marriage in the State of Missouri; (5) not be Medicare eligible; (6) not be a renter, boarder or tenant; and (7) be the employee’s sole sponsored dependent.

Appropriate documentation or forms must be provided to the Plan Administrator to establish eligibility.

(3) Child(ren) of a covered Active Employee or Retired Employee.

An Employee's "Child" includes his/her natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

If a covered Employee, Spouse or Sponsored Dependent is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

For Coordination of Benefits purposes, the following must be provided to the Claims Supervisor: Custody, guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed. Custodial parent is the parent awarded physical custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Coverage will not continue beyond 31 days of placement unless written application and any required Employee contribution has been paid to us before that 31st day. The child’s coverage will continue subject to any required contributions until the earlier of: (a) the day the child is removed from the Employee’s physical custody prior to legal adoption; or (b) the day the coverage would otherwise end in accordance with the Plan provisions.

Any child of an Employee who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan as of the date of the request on the QMCSO. The Employee may elect coverage if not already covered under this Plan. (Refer to the Special Enrollment section.)

In all cases, to qualify as an eligible Dependent under the Plan, the child must be a dependent of the Employee/Retiree. The Plan Administrator may require documentation proving dependency. Proof that a child is your dependent is established by one (1) of the following types of evidence:

(a) For a natural child born to married parents, a copy of the public record of birth showing the Employee was named as parent of the child. For a natural child born to unmarried parents, a copy of the public record of birth showing the Employee was named as parent of the child, as well as any other documentation that the Plan Sponsor may require, including but not limited to DNA testing;
For an adopted child or a child Legally Placed for Adoption, except in jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, evidence of relationship will include a copy of the decree of adoption or as copy of the adoptive placement agreement and such other evidence as may be necessary. In jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, a copy of the child’s revised birth certificate will be accepted to establish the fact of adoption;

For a step-child, evidence of relationship of a step-child will consist of proof of birth as required for a natural child plus proof of marriage of the Employee to the natural parent of the child;

For Legal Guardianship, a copy of the public record showing the Employee and/or Spouse or Sponsored Dependent was named as Legal Guardian of the child.

For Coordination of Benefits purposes, the following must be provided to the Claims Supervisor: Custody, guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed. Custodial parent is the parent awarded physical custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

In the event there is a change in status of any Employee’s Dependent covered under the Plan following the initial eligibility determination, the Employee must inform the Plan Administrator of the change in status and provide documentation to the Plan Administrator that substantiates such a change in status. In the event of death or divorce, a copy of the death certificate or divorce decree will be required. In the event of adoption or placement for adoption, or acquisition of a step-child, documentation described above for each such situation will be required.

The Dependent Child(ren) of a Retired Employee who has been covered under the Plan may be continued on the Plan, even though the Retired Employee is not covered due to eligibility for Medicare Part A, until such date as the child(ren) is no longer eligible as a Dependent as described herein.

(4) Totally Disabled Child of a Covered Active Employee or Retired Employee.

A covered Dependent Child, who prior to reaching the limiting age prior to January 1, 2018, and who prior to reaching the limiting age, was Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. A Dependent child who becomes Totally disabled after reaching the limiting age is not eligible to be enrolled on this Plan. A new Employee will not be able to enroll a Dependent child who is over the limiting age and is Totally Disabled. A terminated Employee who is rehired is considered a new Employee for the purposes of this provision. No Dependent Child shall be covered pursuant to this paragraph after January 1, 2018, if the Dependent Child was not covered pursuant to this paragraph prior to January 1, 2018. The Plan Administrator may require, at reasonable intervals continuing proof of the Total Disability and dependency. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined and; the Legally Separated or divorced former Spouse or former Sponsored Dependent of the Employee or Retiree; or any person who is on active duty in any military service of any country.

Dependents who are also Employees of the University

If a Full Time Employee is also eligible as a Dependent (Spouse or child), they Dependent Child may choose to be covered as an Employee or to decline individual coverage and be covered as a Dependent. If a Dependent Child of an Employee is under the age of 26 and is also a Full-Time Employee, the Dependent Child may choose to be covered either as an Employee or as a Dependent of the parent (mother, father, step-parent, guardian, etc.) who is an Employee, but not both. The Dependent ChildHe or she would be eligible for Dependent coverage up until their 26th birthday at which time Employee coverage could be elected. However, if declining individual coverage, the Employee enrolled as a Dependent will be responsible for the full cost of dependent coverage. If they elect to be on the Plan as a Dependent, they will not receive employer funding that normally applies to
Employee coverage. As a Dependent, they are not eligible for any wellness incentives that would reduce the Employee premium. Employees cannot be enrolled as both an Employee and Dependent.

Dependent children may only be covered under one Employee (regardless of marital status to each other) (double coverage is not allowed).

In the case of Employees married to one another with or without Dependents, one of the Employees may choose to decline individual coverage and be covered as a Dependent of the other Employee along with the Dependent Children. By enrolling as a Dependent, family deductible could be met sooner.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums depending upon the coverages elected and which Covered Persons elect those coverages.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

FUNDING

Cost of the Plan. The amount of contributions, if any, to the Plan are to be made on the following basis:

The University shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the University and the amount to be contributed, if any, by each Participant.

Notwithstanding any other provision of the Plan, the University's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the University's obligation with respect to such payment.

In the event that the University terminates the Plan, then as of the effective date of termination, the University and Participants shall have no further obligation to make additional contributions to the Plan.

Active Employees electing to be covered under the Plan will contribute a portion of the cost for individual coverage which will be set as a percentage of the total cost for individual coverage. The Active Employee contribution may be waived. Covered Active Employees who elect Dependent coverage pay the entire cost for coverage for their Dependents.

The enrollment application for coverage, which includes a payroll deduction authorization, must be filled out, signed and returned to complete the enrollment process.

The level of any Participant contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Participant contributions.

ELECTION TO DECLINE COVERAGE

This is an advisory statement for those individuals who decline coverage explaining the impact of that decision and the "special events" circumstances that would offer him/her "Special Enrollment Periods" in the future.

If you are declining enrollment for yourself or your dependent(s), which includes your spouse or Sponsored Dependent, because of other health insurance coverage (including, but not limited to, Medicare, Medicaid, COBRA, group health plans and some individual policies), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty-one (31) days after your other coverage ends. In addition to the above, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or Legal Guardianship, you may be able to enroll yourself or your dependents, provided that you request enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption or Legal Guardianship. If you apply for coverage other than at the above mentioned situations, you will be subject to the Late Enrollment provisions of the Plan.

IF YOU DECLINE COVERAGE UNDER THIS HEALTH PLAN AND DO NOT DIVULGE TO THE PLAN THAT THIS REASON IS DUE TO OTHER HEALTH INSURANCE COVERAGE, AND SUBSEQUENTLY HAVE A HEALTH COVERAGE CHANGE (SEE SPECIAL ENROLLMENT DEFINITIONS), SPECIAL ENROLLMENT PERIODS THAT MIGHT OTHERWISE HAVE BEEN AVAILABLE TO YOU DUE TO THAT HEALTH
COVERAGE CHANGE WOULD NOT APPLY. AS A RESULT, YOU AND/OR YOUR DEPENDENT(S) WILL BE SUBJECT TO THE LATE ENROLLEE/ENROLLMENT PROVISIONS OF THE PLAN.

ENROLLMENT

Enrollment Requirements for newly hired Active Employees. An Employee must complete the necessary online enrollment forms for the Employee and Dependents to be enrolled in the University’s Group Medical Insurance Plan. If there is a problem accessing the online enrollment form, the enrollment form can be obtained from the Plan Administrator. Enrollment must be completed within the 31-day period after becoming eligible for coverage from when eligible to enroll.

If coverage is not elected when first eligible, the Covered Persons will be considered a Late Enrollee.

Enrollment Requirements for Newborn Children. If the Active Employee has Dependent coverage, and the premium for the coverage is unchanged by adding the newborn, the newborn will be automatically enrolled in the Plan from the moment of birth. An online enrollment form should be filed completed with the Plan Administrator as soon as possible to ensure that accurate information on the newborn is available for adjudication of claims. (Note: When both parents are Employees, the Dependent Children may only be enrolled under one covered parent, not under both.)

If the Active Employee is the mother of the newborn and she does not have Dependent coverage and the premium for the coverage is changed by adding the newborn, the newborn will be covered from the moment of birth through the 31st day following birth. To continue coverage beyond the first 31 days, the online enrollment form must be filed completed with the Plan Administrator before the end of the 31-day period and any premiums due must be paid. If there is a problem accessing the online enrollment form and the enrollment form is obtained from the Plan Administrator within the 31-day period, the Employee has 10 additional days to return the form to the Plan Administrator.

If the Active Employee is the father of the newborn and he does not have Dependent coverage and the premium for the coverage is changed by adding the newborn, the newborn will only be covered from the moment of birth if the online enrollment form is filed completed with the Plan Administrator and any premiums due are paid within 31 days of the child’s birth. If there is a problem accessing the online enrollment form and the enrollment form is obtained from the Plan Administrator within the 31-day period, the Employee has 10 additional days to return the form to the Plan Administrator.

Such coverage for a newborn includes: routine nursery care or the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or complications resulting from prematurity. (Refer to Hospital Services and Physician Services in the Schedule of Benefits).

Charges for covered Well Newborn Nursery Care will be applied toward the Plan of the newborn child.

Charges for covered Well Newborn Physician Care will be applied toward the Plan of the newborn child.

TIMELY AND LATE ENROLLMENT

Note: Enrollment and disenrollment must follow Cafeteria Plan guidelines

(1) Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (father and mother) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) Late Enrollment - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment. Disenrollment must follow Cafeteria Plan guidelines.

The annual open enrollment period, typically held in November or December will be announced by the Employer and detailed information will be provided to the Employees. During this time, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. Covered
Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next January 1st unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse’s employment. To the extent previously satisfied and if applicable, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her Spouse or Sponsored Dependent) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator. (Refer to General Plan Information section for contact information.)

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of Legal Separation, divorce, death, termination of employment or reduction in the number of hours of employment) or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the online enrollment is completed, enrollment form is received, unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons.
(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the online enrollment is completed, enrollment form is received, unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Dependent beneficiaries. If the Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and:

(a) A person(s) becomes a Dependent of the Employee through marriage, then the new Dependent(s) (Spouse/Sponsored Dependent and step-children) and if not otherwise enrolled, the Employee may be enrolled under this Plan as a Covered Person; or

(b) A person becomes a Dependent of the Employee through birth, Legal Guardianship, Qualified Medical Child Support Order (QMCSO), adoption or placement for adoption, then the new Dependents may be enrolled under this Plan as a covered Dependent of the covered Employee. The Spouse or Sponsored Dependent of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Sponsored Dependent is otherwise eligible for coverage.

Eligible Dependents other than those described in (a) or (b) who were not enrolled when first eligible are not eligible to enroll during this Special Enrollment event. They may enroll as Late Enrollees, if allowed by the Plan.

If the Employee is not enrolled in the Plan, he or she may enroll as a Special Enrollee as a result of the Special Enrollment events listed in (a) and (b) above. The newly eligible Dependents may not enroll if the Employee does not elect coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption or Legal Guardianship or the commencement of the school term. To be eligible for this Special Enrollment Period, the Employee must request enrollment of the Plan Administrator during this period. Otherwise, the person is considered a Late Enrollee and will be subject to the Late Enrollment provisions under this Plan. The exception may be the enrollment of newborns. Refer to the Enrollment Requirements of Newborn Children in this Enrollment section.
The coverage of the Dependent enrolled in the Special Enrollment Period will be effective no later than the following unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons:

(a) in the case of marriage, no later than the first day of the first month beginning after the date the completed request for enrollment is received (i.e., marriage occurred on January 10. If the online enrollment form is received completed between January 10th and 31st, the effective date will be no later than February 1. If the online enrollment form is received completed between February 1st and 9th, the effective date will be no later than March 1.);

(b) in the case of a Dependent’s birth, as of the date of birth; or

(c) in the case of a Dependent’s adoption or placement for adoption or Legal Guardianship, the date of the adoption or placement for adoption or Legal Guardianship.

(4) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

PAYROLL PREMIUM DEDUCTIONS: In order to have the Enrollment Date listed above, it may be necessary to make double, triple or quadruple payroll premium deductions due to the Plan’s criterion of paying the premium one month in advance of the coverage effective date.

If the Employee chooses not to have multiple premiums deducted from their payroll to satisfy the advance payment criterion, the Enrollment Date will be the first of the month for which a premium deduction can be made. As a result, the newly enrolled individual will be considered a Late Enrollee and be subject to the Late Enrollment provision of this Plan. Charges incurred prior to the Enrollment Date will not be considered eligible expenses.

EFFECTIVE DATE

Effective Date of Active Employee Coverage. Active Employee coverage shall become effective with respect to an eligible person on the first day of the calendar month, or applicable premium period:

(1) Faculty and Non-Faculty: The first of the month following the date of employment or the first of the month following employment if the date of employment if it is other than the first business day of the month.

(2) Non-Faculty: First of the month following thirty (30) days of employment.

Active Employee. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

The period of time between the date of employment and the first day of coverage under the plan is referred to as a “waiting period.”

Effective Date of Retiree Coverage. Eligible Retired Employees’ coverage shall become effective with respect to an eligible person on the first day of the month for which the required premium has been paid.

(1) Faculty and Non-Faculty: First of the month following retirement.

(2) Non-Faculty: First of the month following thirty (30) days from retirement.

Retired Employee. A Retired Employee must have been an Active Employee (as defined by this Plan) and have elected to pay for the continuation of that coverage (either single or dependent) which was in effect at the time of
Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; all Enrollment Requirements are met and appropriate premiums have been paid. The effective date of that coverage will be as follows:

(1) on the day that the Active Employee’s coverage becomes effective at the time of employment; or

(2) if the Active Employee enrolls the Dependent within 31 days of his/her employment, coverage will become effective the first of the month following the Active Employee’s effective date; or

(3) if the Active Employee enrolls the Dependent as a result of a Special Enrollment Period, the effective date of coverage will be:
   (a) In the case of marriage, either the date of eligibility, the first of the month after the date of eligibility or the first of the month beginning after the date the completed request for enrollment is received;
   (b) In the case of a Dependent's birth, as of the date of birth; or
   (c) In the case of a Dependent's adoption or placement for adoption or Legal Guardianship, the date of the adoption or placement for adoption or Legal Guardianship.

(4) If the Active Employee enrolls the Dependent after the 31 days from the date of the Dependent's eligibility date, the Dependent is considered a Late Enrollee and must follow the Late Enrollment provisions of this Plan.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Covered Persons will receive a notice that will show the coverage period under this Plan.

When Participant Coverage Terminates. Participant coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Participant may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Participant's Eligible Class is eliminated.

(3) The date of death of the covered Participant. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) For Faculty and Non-Faculty: The last day of the calendar month in which the covered Participant ceases to be in one of the Eligible Classes. This includes termination of Active Employment of the covered Active Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

For Non-Faculty: The date on which the covered Participant ceases to be in one of the Eligible Classes. This includes termination of Active Employment of the covered Active Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The last day of the stability period in which the covered Participant ceases to be in one of the Eligible Classes but remains employed by the Employer. This includes Employee approved leaves of absence, disability, suspension, lay-offs, lock outs or not working due to work stoppage; or if the Employee does not satisfy the requirements for hours worked or any other eligibility condition in the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

(56) The last day of the calendar month in which the Participant elects to terminate coverage. (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.) (See the section entitled Continuation Coverage Rights under COBRA.)

(67) The last day the University and/or the Participant made any required contribution for the coverage if the full premium for the next period is not paid when due for COBRA or retiree coverage. If an Employee/Retiree no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as
stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.

(78) If a Participant commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may rescind coverage for the Participant for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or intentional misrepresentation of material fact, the Plan will provide at least 30 days advance written notice of such action.

When Retired Employee Coverage Terminates.

(1) A Retired Employee, or the Spouse, Sponsored Dependent or eligible Dependent of a Retired Employee, who becomes eligible for Medicare benefits for any reason will no longer be eligible for coverage under the Plan. If such person subsequently loses such Medicare benefits before age 65, he/she is eligible for re-enrollment in the Plan. If this person elects to re-enroll in the Plan, re-enrollment must be completed within thirty (30) calendar days from the date the Medicare benefits ceased. The person must also meet all other eligibility requirements of the Plan at the time of his/her re-enrollment. Such enrollees are subject to the eligibility and all other Plan provisions in order to maintain his/her coverage under the Plan. Upon re-enrollment, the person may continue to be covered under the Plan until such date as the person is eligible for Medicare Part A, whether such eligibility is the result of reaching the Medicare eligibility age or other reason. In the case of the Dependent of a Retiree, such Dependent may continue to be covered under the Plan until such date as the Dependent no longer qualifies as a Dependent as defined by this Plan.

(2) The date the Retiree elects to terminate coverage if earlier than (1) above.

Continuation During Periods of Family Medical Leave Act leave (FMLA), Employer-certified disability leave, Employer-approved Leave of Absence or lay-off. A person may remain eligible for a limited time if active, full-time work ceases due to one of the preceding events. The Employer will notify the Employee of any applicable increase in premium contributions. This continuance will cease on the date that the University stops paying the required premium for the Active Employee, or otherwise cancels the Active Employee’s coverage. Regardless of these established leave policies, the Employer meets the requirements of the Family and Medical Leave Act of 1993 (including all amendments) as established in regulations issued by the Department of Labor.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

If coverage terminates under this Plan during the FMLA leave, at the request of the Employee, coverage will be reinstated if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. If a terminated Employee experiences a period without any Hours of Service and resumes Hours of Service and:

(1) if the Employee is rehired following a Break in Service (as defined in the Plan’s Eligibility Appendix), the Employee will be treated as a New Employee and be required to satisfy all eligibility and enrollment requirements under the Plan as stated in the “Eligibility Requirements for Participant Coverage” section.

(2) if the Employee is rehired without experiencing a Break in Service, the Employee will be treated as a Continuous Employee and is eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with no Hours of Service. Such coverage will be effective the first day of the month following the date Hours of Service resumes.

(3) if the Employee was continuously covered as a COBRA participant of this Plan, a new employment waiting period does not have to be satisfied and coverage will change to Active Employee status as of the first of the month following the date Hours of Service resumes.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA).
These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

1. The date the Plan or Dependent coverage under the Plan is terminated.
2. The date that the Active Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
3. On the last day of the calendar month that a covered Spouse or Sponsored Dependent loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
4. On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
5. The last day of the calendar month in which the Participant requests that a Dependent's coverage be terminated. (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.) This termination is typically not a COBRA qualifying event.
6. The end of the period last day for which the University and/or Participant made any the required contribution for the coverage has been paid if the full premium for the next period is not paid when due for COBRA or retiree coverage. If a Dependent no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.
7. If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or intentional misrepresentation of material fact, the Plan will provide at least 30 days advance written notice of such action.

The Employee shall be responsible for notifying the Plan Administrator of new Eligible Dependents and of any changes in the eligibility status of a Dependent. (Refer to the COBRA section.) Benefits provided to an ineligible Dependent will be recouped by the Plan in accordance with its rights for reimbursement. Employee contributions paid for a period when the Employee knew or should have known the Dependent was ineligible will not be reimbursed to the Employee.
MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will accrue toward the 100% maximum out-of-pocket payment. It does not count toward the coinsurance maximum.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year. The most that an individual Covered Person may contribute toward the Family Unit Participating-Network Provider Deductible is the maximum amount of the individual Covered Person Participating-Network Provider deductible as listed in the Schedule of Benefits, even if the Covered Person has paid the higher Non-Participating-Network Provider individual covered Person deductible amount.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident. These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Refer to the Schedule of Benefits for a list of charges that are included and not included in this limit. Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable as shown in the Schedule of Benefits (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable as shown in the Schedule of Benefits (except for the charges excluded) for the rest of the Calendar Year.

When a Covered Person elects COBRA, he/she will only receive credit for any individual deductible and coinsurance amounts applied on services incurred prior to the COBRA coverage date. Individual deductible and/or coinsurance amounts applied to claims with dates of service incurred after the COBRA coverage date will not apply toward the prior active family accumulated totals. A Family Unit for Covered Persons who elect COBRA will be the following: Employee plus Spouse or Sponsored Dependent; Employee plus child(ren); family; and Spouse or Sponsored Dependent plus children. Dependent Children who elect COBRA without a parent will be covered as separate individuals. Covered Persons in a Family Unit on COBRA will accrue their individual totals toward the Family Unit totals.

COVERED CHARGES

These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) Hospital Care. The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits.

The Allowed Amount for room charges made by a Network Hospital having only private rooms will be the Network contracted rate.

If a Non-Network Hospital having only private rooms is utilized, the Allowed Amount for eligible room charges will be at 80% of the facility's billed private room rate, the Usual and Customary Allowance or the contracted rate, whichever is less. If the Hospital/Physician assigns the patient to a private room due to Medical Necessity, the Allowed Amount will be the billed room rate. The admitting
Physician must provide documentation of the Medical Necessity to the Claims Supervisor prior to or along with the Hospital claim for prompt consideration of the billed charges.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

**Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse or Sponsored Dependent. There is no coverage of Pregnancy for a Dependent Child.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (i.e., Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a **Physician or other health care provider** obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, the Covered Person may be required to obtain precertification. The **Covered Person** is responsible for the Precertification process. (Refer to the Cost Management Section.) The 48- or 96-hour inpatient stay begins at the time the delivery occurs in the Hospital. For deliveries occurring outside of the Hospital, the stay begins at the time the mother and/or newborn are admitted as an inpatient to a Hospital.

**Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the confinement starts within 14 days of a Hospital confinement of at least 3 days or following a period of Home Health Care that was covered by the Plan; and

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement;

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility. The care must be likely to result in a significant improvement in the Covered Person's condition; and

(e) the degree of care must be more than can be given in the Covered Person's home, but not so much as to require acute hospitalization.

In lieu of the above criteria, services will be covered if they are precertified/authorized as Medically Necessary through the Utilization Review program.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

**Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures, Physician's Assistants and Nurse Practitioners** will be a Covered Charge subject to the following provisions, except claims for certain PPO network providers which will be based upon the network contracts and reduced by the PPO prior to filing the claim with the Claims Supervisor:

(a) If Bilateral or Multiple Surgical Procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Customary Allowance for the primary procedures; 50% of the Usual and Customary Allowance for each additional procedure performed through the same incision; and 70% of the Usual and Customary Allowance for each additional procedure performed through a separate incision. Any procedure that would not be an integral part of
the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Allowance for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Customary Allowance for that procedure; and

(c) If an assistant surgeon (another Physician or Certified First Assistant) is required (according to Medicare guidelines), the assistant surgeon's covered charge will not exceed 20% of the surgeon's contract rate, Usual and Customary Allowance, or billed charges, whichever is less. If the acting assistant surgeon is a physician's assistant or nurse practitioner, the covered charge will not exceed 13.6% of the surgeon's contract rate, the network rate established in the contract, Usual and Customary Allowance or billed charges, whichever is less;

(d) If a physician’s assistant or nurse practitioner bills for covered services, office visits and surgical procedures other than as an assistant surgeon (see above), the covered charge will not exceed 75% of the M.D. or D.O.’s contract rate, Usual and Customary Allowance or billed charges, whichever is less.

(5) **Telemedicine/Telehealth/Telemonitoring.** Telehealth is the use of electronic information and communication technologies by a health care provider to deliver health care services to a patient while such individual is located at a different site than where the health care provider is located. Telehealth can provide remote access to services such as medical consultations and information, health assessments and diagnosis. Telehealth services are provided to a patient by a healthcare professional through interactive telecommunications devices. Similar to telemedicine, telehealth offers a convenient way for patients in need of frequent follow-up or assessment to receive the services they need when they need them without having to worry about the logistics of traveling to the healthcare professional’s office.

Telemedicine is the use of interactive telecommunication devices between a patient and a healthcare professional for the purpose of improving or maintaining the health of the patient. Interactive telecommunication devices consist of audio and visual equipment capable of transmitting two-way, real-time (synchronous) communications between a patient and healthcare professional over a distance from multiple locations. Telemedicine can offer a convenient method of delivering healthcare to patients in rural or underserved areas that may otherwise have limited or no access to the healthcare professionals they need.

Telemonitoring, which can encompass telehealth, also includes, for example, the use of electronic remote monitoring devices for purposes such as blood pressure checks, weight checks via a teloscale for patients with Congestive Heart Failure (CHF) as well as other remote medical intervention and assessment tools from the convenience of the patient’s place of residence.

Standard telephone calls, fax transmissions and email, in the absence of other integrated information and data, do not qualify as a Covered Charge under this benefit.

Coverage may also be subject to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(56) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary, not Custodial in nature and is in lieu of Inpatient acute care. Outpatient private duty nursing care must be preauthorized by the Utilization Review Coordinator. Services are subject to the benefits shown in the Schedule of Benefits and below under Home Health Care Services and Supplies. Outpatient private duty nursing on a 24-hour shift basis is not covered.
(67) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits. Services provided by a home health aide are covered if in conjunction with Home Health Care provided by a nurse or therapist and the services provided support skilled nursing services. The following services are considered Covered Expenses under this benefit:

(a) Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN);
(b) Part-time or intermittent home health aide services which consist primarily of caring for the patient;
(c) Physical therapy, occupational therapy and speech therapy provided by a Home Health Care Agency;
(d) Medical supplies, laboratory services, drugs and medications prescribed by a Physician.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Expenses incurred in connection with home health care visits are covered under the Plan provided:

(a) the services are preauthorized as Medically Necessary through the Utilization Review Program,
(b) the services are rendered in accordance with a treatment plan submitted by the attending physician, and
(c) in-patient confinement in a Hospital or Skilled Nursing Facility would be required in absence of Home Health Care.

(78) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Covered Charges for in-patient Hospice Care include room and board and other services and supplies furnished for pain control and other acute and chronic symptom management.

Covered Charges for out-patient Hospice Care include charges for:

(a) part-time or intermittent nursing care by an R.N. or L.P.N. as needed to meet the person's assessed needs;
(b) psychological and dietary counseling;
(c) consultation or case management services by a Physician;
(d) physical therapy;
(e) part-time or intermittent home health aide services; and
(f) medical supplies, drugs, and medicines prescribed by a Physician.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse/ Sponsored Dependent and/or covered Dependent Children) are a covered expense. Bereavement services must be furnished within one year after the patient's death. (Refer to the Schedule of Benefits for benefit limitations.)

(89) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy Treatment.** Evaluation, diagnosis and treatment of allergies (immunotherapy).
Ambulance. Local Medically Necessary professional ground or air ambulance service. A charge for this item will be a Covered Charge only if the service is to transport a person from the place where he/she is injured or stricken by disease to the nearest Hospital/Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Ground ambulance is also covered in the following circumstances:

(i) To transport a patient from one Hospital to another nearby Hospital when the first Hospital does not have the required services and/or facilities to treat the patient;

(ii) To transport a patient from Hospital to Skilled Nursing Facility when the patient cannot be safely or adequately transported in another way without endangering the individual’s health, whether or not such other transportation is actually available; or

(iii) To transport a patient from Skilled Nursing Facility to Hospital for Medically Necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the patient.

(iv) To transport a patient from a Non-ParticipatingNetwork Provider to a Participating Network Provider.

Ambulette Service or other forms of passenger transportation that are available to the public (e.g., buses, taxis or airplanes) are not covered. (Refer to Plan Exclusions.)

Air Ambulance is a covered expense in the following circumstances:

(i) When a patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient; and

(ii) Ground ambulance transportation is not medically appropriate because of the distance involved or because the patient has an unstable condition requiring medical supervision and rapid transport.

Except in Life-threatening emergencies, coverage of air ambulance transport requires preauthorization.

Transportation by ground or air for patient convenience or for nonclinical (social) reasons is not covered.

Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

Applied Behavior Analysis (ABA) for Autism Spectrum Disorders (ASD). ABA intervention shall produce socially significant improvements in human behavior through skill acquisition, increase or decrease in behaviors under specific environmental conditions and the reduction of problematic behavior. The services must be Medically Necessary treatment ordered by the treating Physician or psychologist in accordance with a treatment plan. An ASD treatment plan must include all elements necessary for this Plan to pay the claim. The Plan has the right to review the plan once every six months unless the treating Physician or psychologist agrees that more frequently is necessary.

For purposes of this benefit, educational and habilitative therapies are covered when part of the treatment plan.

Payments and reimbursements for ABA therapies can only be made to the ASD service provider or the entity or group for whom the supervising board certified behavior analyst works or is associated. ABA services provided by a line therapist under the supervision of a state-licensed ASD provider must be reimbursed to the provider if the services are included in the treatment plan and are deemed Medically Necessary. ABA services provided by any Part C Early Intervention Program (i.e., First Steps) or any school district to an individual diagnosed with ASD is not covered under this Plan.

The benefit limit stated in the Schedule of Benefits may be exceeded upon prior approval by the Claim Supervisor and/or the Plan Administrator after Medical Necessity has been established. This limit will be reviewed and adjusted every three years beginning January 1, 2012, based upon the increase in the federal Consumer Price Index as calculated by the applicable federal department.
(e) **Blood sugar kits (glucometers)** are a covered expense when Medically Necessary.

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(gf) **Chemotherapy**, radiation or other treatment with radioactive substances. The materials and services of technicians are included.

(hg) **Chiropractic Services** by a licensed D.C. All services (manipulations, non-manipulation office visits, evaluations, labs, x-rays, etc.) rendered by a chiropractor will be applied to the Spinal Manipulation/Chiropractic Services maximum stated in the Schedule of Benefits. General anesthesia, IV sedation and maintenance or preventive care visits are not covered. No benefits for Chiropractic Care will be paid under any other section of the Plan.

(h) **Routine patient care charges for Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition (which means likely to result in death unless the disease or condition is interrupted). For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(i) **Contact lenses or glasses** initially required following eye surgery, except surgeries to correct refractive disorders. In this case, rose-tinting, scratch-resistant coating and the additional charge for progressive lenses are considered cosmetic and not covered. However basic tinting, frames and up to tri-focal lenses are covered. If surgery is performed on one eye and then the second eye within 2 years, only the second lenses will be covered and not a new pair of glasses. If later than that time period, a full pair of glasses will be covered. Accommodating Intra-Ocular Lenses used to replace the lens of the eye following cataract surgery are not covered under this Plan.

(j) **Durable medical or surgical equipment.** Rental if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Sales tax and shipping charges on covered equipment are covered expenses. Shipping charges solely for the patient's convenience will not be covered. DME includes, but is not limited to, crutches, trusses, catheters/ostomy supplies, self-injection supplies for diabetics, wheelchairs, Hospital beds, oxygen/administration equipment, etc.

Rental fees, but not to exceed, in aggregate, the purchase price, for Durable Medical Equipment made and used only for treatment of injury or Illness.

Replacement of durable medical equipment will be considered a Covered Expense when Medically Necessary and appropriate and when repairs are cost prohibitive. Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. Power-operated vehicles may be replaced no more often than every five years and if repair is cost-prohibitive or is Medically Necessary due to a change in the Covered Person's physical condition.

(k) **Educational training.** One Medically Necessary unit of educational training is allowed per illness per lifetime, however, subject to approval by the Utilization Review Coordinator a new unit will be allowed when one of the following occurs: a change in diagnosis, prescribed treatment or prescribed supplies (i.e., non-insulin dependent to insulin dependent diabetes;
(l) Genetic testing is covered if it aids diagnosing of a Covered Person with functional abnormalities or who is symptomatic of an Illness which may be inheritable and the results of the test will impact the treatment being delivered.

(m) Hearing aid. The initial purchase of a hearing aid if the loss of hearing is the result of a surgical procedure performed while coverage is in effect.

(n) Hearing exams and hearing aids for newborns. Coverage for newborn hearing screening, necessary newborn rescreening, audiological assessment and follow-up, and initial amplification in accordance with Missouri Law.

(no) Laboratory studies. Covered Charges for diagnostic and preventive lab testing and services.

(op) Mental Disorders and Substance Abuse. Benefits imposed by the Plan shall comply with federal parity requirements, if applicable. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D. or L.P.C.) or Licensed Clinical Social Worker (L.C.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of these professionals.

Benefits are payable under this provision for Mental Disorders and Substance Abuse upon the diagnosis and recommendation of a Physician. Such effective treatment must meet all of the following tests.

(i) The treatment facility, either inpatient, outpatient or at a Residential Treatment center, is appropriate for the diagnosis.

(ii) Treatment is prescribed and supervised by a Physician within the scope of his license.

(iii) Treatment includes a follow-up program, as appropriate, which is Physician directed; and

(iv) Treatment includes patient attendance, as appropriate, at meetings of organizations devoted to the therapeutic treatment of the illness.

Treatment solely for detoxification or maintenance care is not considered effective treatment and is not covered under this provision. "Detoxification" means care is aimed primarily at overcoming the after-effects of a specific drinking or drug episode and "maintenance care" means providing an environment free of alcohol or drugs. Detoxification in conjunction with appropriate therapeutic treatment is covered under this provision.

(pq) Mouth, teeth and gums. Treatment is covered as follows:

(i) Care of mouth, teeth and gums. Charges for care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures or for diagnostic and office visit charges for evaluation of the following services (Note: Tooth extractions will only be covered as listed below. If not listed, extractions are not covered.):

(a) Excision of bony growths of the jaw and hard palate.
(b) Excision or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, hard palate and floor of the mouth.
(c) Incision and drainage of cellulitis.
(d) Incision of sensory sinuses, salivary glands or ducts.
(e) Osteotomy (jaw surgery when not connected to treatment of TMJ) which is Medically Necessary and not cosmetic in nature.
Removal of teeth for the medical management of a hazardous medical condition to include but not limited to the following: anticoagulation, valvular heart disease, hemophilia, preparation for cancer treatment in the neck/head region. Initial office visit and diagnostic services will be covered when connected to the services to remove the teeth. Documentation of the Illness should be submitted with the charges.

This Plan will cover the Usual and Customary allowance for the replacement of any teeth that were required to be removed for this treatment.

Hospital Facility and anesthesia charges for pediatric or adult dental procedures that require the use of anesthesia in an Outpatient Surgical Center facility or Hospital setting for the following Covered Persons:

(i) A child under the age of five;
(ii) A person who is severely disabled; or
(iii) A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Services must be Medically Necessary due to an underlying medical condition requiring this setting. Physician's charges for the dental procedure are not eligible under this Medical Plan unless stated as covered in the Medical Benefits above. Documentation of the Medical Necessity should be submitted with the charges.

If the Covered Person has elected coverage under the Employer's self-funded dental plan, anesthesia charges in the Physician's office will first be eligible under the dental plan and then coordinate coverage under this medical Plan.

Injury to or care of mouth, teeth and gums. Charges for repairs to the mouth, teeth, gums and alveolar processes due to an Injury will be Covered Charges under Medical Benefits only if that care is for the following oral procedures:

(a) Repair (or replacement when necessary):

(i) Due to Injury to the mouth, teeth or gums;
(ii) Of any appliance in the mouth at the time of the Injury; or
(iii) Of previously repaired/replaced teeth due to the Injury.

(b) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Injury as a result of chewing or biting is not considered an accidental Injury.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, dental implants or preparing the mouth for the fitting of or continued use of dentures unless specifically addressed in the benefit. If the Covered Person chooses dental implants as the alternative treatment for the repair/replacement of the teeth, the Plan will allow the coverage up to the amount allowed for a lesser treatment, i.e., bridge. The Covered Person will be responsible for all charges above that amount.

(q) Occupational therapy by a licensed occupational therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician, result from an Injury or Sickness, improve a body function and treat conditions which are subject to significant improvement through short-term therapy. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act.
Organ transplant limits. All Organ Transplant services, including evaluation, must be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator (Refer to General Plan Information section for contact information) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

DEFINITIONS. For purposes of this section, the following definitions apply.

Approved Transplant: A human organ or bone marrow transplant procedure currently performed at a Designated Transplant Facility.

Approved Transplant Services: Medically Necessary services and supplies which are related to an Approved Transplant procedure; are approved in writing under the Precertification and/or Preauthorization process; and include but are not limited to:

1. Pre-transplant patient evaluation for the Medical Necessity of the transplant.
2. Hospital charges.
3. Physician charges.
4. Tissue typing and ancillary services.
5. Organ procurement or acquisition.

Center of Excellence: A Designated Transplant Facility that has a Medicare-approved transplant program and is recognized by the United Network for Organ Sharing (UNOS) and the National Marrow Donor Program (NMDP) (non-profit organizations under contract with the United States Department of Health and Human Services to coordinate organ and bone marrow donation and distribution). These organizations have set standards for physical facilities, laboratory capabilities for organ and tissue matching, the recipient selection process and the availability of specialized services. The criteria used for selection of a Designated Transplant Facility are intended to ensure that approval is given only to facilities with the necessary experience and expertise to perform these complex surgeries successfully.

Medicare-approved medical centers must meet extensive criteria set out by Centers for Medicare & Medicaid Services (CMMS) and a review board comprised of transplant surgeons, specialists, and other clinicians and scientists. A facility must have Medicare-approval status before it can receive payment for transplantation services provided to Covered Persons.

All Designated Transplant Facilities must offer comprehensive services that include experts in many medical specialties, such as radiology, infectious disease and pathology, as well as a range of allied health services that may include physical therapy, rehabilitation and social services.

Clinical Practice Guidelines: Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

Designated Transplant Facility: A Center of Excellence facility which has an agreement with the Plan Administrator or Claims Supervisor to render Approved Transplant Services to Covered Persons. This agreement will be made through a national organ transplant network and may not be located in the person’s geographic area. Contact the Utilization Review Coordinator for a list of facilities.

Non-designated Transplant Facility: A facility which does not have an agreement with the Plan Administrator or Claims Supervisor to render approved Transplant Services to Covered Persons.

Transplant Benefit Period: The period of time from the date the person receives prior authorization and has an initial evaluation for the transplant procedure until the earliest of:
(a) one year from the date the transplant procedure was performed.
(b) the date coverage under the Plan terminates.
(c) the date of the Covered Person’s death.

If, during the same admission as the initial transplant a retransplant occurs, the period of time is one year from the date of the initial transplant. If a retransplant will be done during a subsequent admission, a new Transplant Benefit Period starts from the date the person receives authorization for the retransplant.

(ii) DESIGNATED FACILITIES FOR APPROVED TRANSPLANT SERVICES

This provision only applies to transplant procedures listed in the definition of Approved Transplant.

Transplant procedures must have preauthorization. The Covered Person or his/her Physician must call the toll free number provided for this purpose. Retransplantation procedures must also have preauthorization.

If the Physician and the Plan Administrator or Claims Supervisor does not agree that the transplant procedure is Medically Necessary and appropriate, the Covered Person will be informed in writing of the right to a second opinion. A Board Certified Specialist must be utilized for this second opinion.

A person who will be undergoing a transplant procedure will be referred to a Designated Transplant Facility. This referral and authorization for services at a Designated Transplant Facility shall continue to be appropriate through the Transplant Benefit Period.

If the Covered Person is denied the procedure by the Designated Transplant Facility, he/she may be referred to a second such facility for evaluation. If the second facility determines, for any reason, that the person is not an acceptable candidate for the procedure, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the services or supplies are provided at a third Designated Transplant Facility or at a Non-designated Transplant Facility.

(iii) BENEFITS

Benefits for Approved Transplant Services provided during a Transplant Benefit Period will be paid as shown in the Schedule of Benefits. Benefits will be different for services provided at a Designated Transplant Facility than services provided at a Non-designated Transplant Facility. Other transplant procedures will be considered for benefit payment according to the provisions of the Plan.

Benefits will be paid for expenses incurred for Approved Transplant Services done at a Designated Transplant Facility as follows:

The transplant must be performed to replace an organ or tissue.

Donor charges:

(a) Charges for obtaining donor organs or tissue for a covered recipient are considered Covered Charges under this Plan. The donor’s expenses will be applied toward the benefits of the covered recipient.

Donor charges include those for:
- evaluating the organ or tissue;
- removing the organ or tissue from the donor.
- transporting the organ within the United States and Canada to the place in the US where the transplant is to take place.

(b) If the organ donor is a Covered Person and the recipient is not, then this Plan will always pay secondary to any other coverage. This Plan will cover donor charges for:
- evaluating the organ or tissue;
- removing the organ or tissue from the donor.
- No transportation charges will be considered.
For procedures done at a Non-designated Transplant Facility, the benefits listed above will be paid as shown in the Schedule of Benefits. The organ transplant limitations will apply.

(iv) **EXCLUSIONS**

No benefits will be paid for any service:

(a) related to the transplantation of any non-human organ or tissue, except for heart valves.

(b) for a facility or Physician outside the United States of America.

(c) which are eligible to be repaid under any private or public research fund.

(s) **Orthotic appliances.** The initial purchase (of a single unit per body part), fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Replacement of orthotics will not be covered unless 1) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 3 years). Replacement of the appliance must be preauthorized. (Refer to Cost Management Services.) The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions items Foot and Hand Care and Orthotics for further information.) Preauthorization of services and/or treatment recommended.

(t) **Physical Therapy** by a licensed physical therapist or licensed physical therapy assistant. Preauthorization of therapy is required. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration, to improve a body function and to treat conditions which are subject to significant improvement through short-term therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. Accepted level of rehabilitation is when the Covered Person can perform basic Activities of Daily Living. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

(u) **Prescription Drugs** (as defined) and supplies. Refer to the Prescription Drug Benefit section for further details on covered and excluded drugs dispensed at a Pharmacy (including a facility's Pharmacy for dispensing take-home medications for use upon release from that facility). Call the Pharmacy Benefit Manager (PBM) at the number on your ID card for complete information about covered and excluded Prescription Drugs and supplies purchased at the Pharmacy.

Prescription Drugs consumed on the premises of a Physician or facility, i.e., a Hospital, urgent care facility or Physician’s office, are covered under the Medical Benefits as stated in the Schedule of Benefits.

A Utilization Review Coordinator may approve some drugs to be allowed under the regular benefits of this Plan.

The following contraceptive Prescription Drugs and/or supplies through a Pharmacy or Physician’s office are covered by the Prescription Drug or Medical Benefits of this Plan: oral, injectable (i.e., Depo Provera), implantable (i.e., Norplant), topical, intravaginal (i.e., ring or diaphragm) or intrauterine (i.e., IUD).

Prescription Drug use does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review (DUR) may be retrospective, concurrent or prospective. Retrospective DUR generally involves claim review and may include
communication by the PBM with prescribers to coordinate care and verify diagnoses and Medical Necessity. Concurrent DUR generally occurs at the point of service and may include electronic claim edits to protect patients from potential drug interactions, drug-therapy conflicts or overuse or under dose of medications. Prospective DUR may include, among other things, therapy guidelines or Physician or Pharmacy assignment in which one Physician or Pharmacy is selected to serve as the coordinator or Prescription Drug services and benefits for the eligible Covered Person.

Preventive Care. Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Preventive care is intended to prevent the onset of an illness or a disease or to provide an early diagnosis of a medical condition which is not known or reasonably suspected by the Physician or patient. Preventive care includes routine, periodic or annual examinations, screening examinations, evaluation procedures and preventive medical care as determined appropriate by the Physician in consultation with the patient. It does not include treatment or services directly related to the diagnosis or treatment of a specific injury, Illness or pregnancy-related condition.

(i) Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness for Covered Persons age 19 and older.

Breast pumps will be covered under this benefit as follows:

(a) Purchase of a dual manual or a standard, dual electric breast pump is covered for all women who choose to breast feed.

(b) Purchase of an electric breast pump is limited to once every three years upon subsequent births.

(c) Supplies necessary for the use of a breast pump, such as tubing and an adapter are covered as needed.

(d) Rental of a heavy duty, hospital grade electric breast pump and purchase of necessary supplies is covered when ordered by a health care provider as Medically Necessary during the time a mother and infant are separated because the infant remains hospitalized upon the mother's discharge. Once the baby is discharged, the continued rental of a hospital grade electric pump is not considered Medically Necessary. The purchase of a standard electric breast pump will then be covered as stated above.

Purchase or rental can begin any time during the first year of the newborn's life. In addition, this benefit includes coverage for counseling/training in use of the breast pump.

The following breast pumps will NOT be covered under this benefit since considered not Medically Necessary:

(a) Purchase of a heavy duty, hospital grade electric breast pump.

(b) Rental of a heavy duty, hospital grade electric pump after the baby is discharged from the hospital.

(c) Replacement supplies for comfort and convenience and milk storage products.

(ii) Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness up to age 19.

Prosthetic devices. The initial purchase, fitting, repair and replacement of fitted prosthetic devices which replace body parts. Replacement of prostheses will not be covered unless (a) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional, or (b) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). Replacement of the device must be preauthorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless
cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for Prosthetic devices for further information.) Preauthorization of services and/or treatment recommended.

Two mastectomy bras are covered every six months; one prosthetic every Calendar Year. Compression stockings are covered with a prescription or Physician’s orders. The prescription must require measurement of the patient for proper fitting. Limit two (2) pair per Calendar Year.

**Pulmonary rehabilitation** as deemed Medically Necessary, Reasonable and Necessary, and Restorative. These services must be rendered: (a) under the supervision of a Physician; (b) for chronic pulmonary disability with reduction of exercise tolerance which restricts the abilities of the Covered Person to perform daily activities and/or work; and (c) in a Medical Care Facility as defined by this Plan. Pulmonary Function Test must show FEV1 of less than 60% predicted. Maintenance programs are not covered.

**Reconstructive Surgery.** Correction of abnormal congenital conditions, repair of damage from an accident or Injury, repair following Medically Necessary surgery for an Illness and reconstructive mammoplasties will be considered Covered Charges.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) states that since the Plan provides coverage for services related to mastectomies, the Plan must provide coverage for:

(i) reconstruction of the breast on which a mastectomy has been performed,
(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
(iii) coverage of initial and replacement prostheses (two mastectomy bras are covered every six months; one prosthesis every Calendar Year) and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

**Speech therapy** by a licensed speech therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or (b) an Injury or Sickness that results in loss of previously acquired speech; or (c) an Injury or Sickness that results in loss of normal swallowing mechanics. Maintenance programs are not covered. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

**Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. (Refer to the Schedule of Benefits for benefit maximum.) General anesthesia or IV sedation for the sole purpose of performing a manipulation is not covered. Also refer to Chiropractic Care in this section.

**Sterilization procedures** *(once per Lifetime).*

**Tobacco Use Cessation Program.** A formalized program of therapy, prescribed medicines and over-the-counter (OTC) nicotine replacement therapies which is under the direction of a trained/certified therapist, counselor, healthcare provider, or Physician with the goal of ending the use of the specific tobacco product. Refer to the Schedule of Benefits for limitations.

**Surgical** dressings, splints, casts, supplies and other implantable devices.

**Therapies** are covered under this Plan as follows:

(i) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
(ii) **Occupational therapy** by a licensed occupational therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician, result from an Injury or Sickness, improve a body function and treat conditions which are subject to significant improvement through short-term therapy. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

(iii) **Physical Therapy** by a licensed physical therapist or licensed physical therapy assistant. Preauthorization of therapy is recommended. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration, to improve a body function and to treat conditions which are subject to significant improvement through short-term therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. Accepted level of rehabilitation is when the Covered Person can perform basic Activities of Daily Living. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

(iv) **Pulmonary rehabilitation** as deemed Medically Necessary, Reasonable and Necessary, and Restorative. These services must be rendered: (a) under the supervision of a Physician; (b) for chronic pulmonary disability with reduction of exercise tolerance which restricts the abilities of the Covered Person to perform daily activities and/or work; and (c) in a Medical Care Facility as defined by this Plan. Pulmonary Function Test must show FEV1 of less than 60% predicted. Maintenance programs are not covered.

(v) **Speech therapy** by a licensed speech therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or (b) an Injury or Sickness that results in loss of previously acquired speech; or (c) an Injury or Sickness that results in loss of normal swallowing mechanics. Maintenance programs are not covered. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

(vi) **Vision therapy.** Charges incurred in connection with vision therapy for rehabilitative therapy after brain injury, including stroke, that are Medically Necessary, Reasonable and Necessary, and Restorative. It is not covered for learning / reading disabilities, to promote learning or for maintenance programs are not covered.

(ffcc) **Weight Management/Control.** Weight-loss programs: Charges for weight-loss programs will be covered if the program is necessary to treat a medical condition by decreasing the patient's weight. This program must be designed to treat health problems associated with high-risk Morbid Obesity/Severe Clinical Obesity and be administered and supervised by a
These health conditions may include hypertension, diabetes, cardiovascular disease and sleep apnea. The Covered Person must have demonstrated unsuccessful results in a weight-loss program. This weight-loss program must include diet, exercise and behavioral components. Documentation of the Covered Person's participation in qualifying programs must be submitted to the Utilization Review Coordinator for approval.

Coverage is limited to Medically Necessary charges for treatment of Morbid Obesity/Severe Clinical Obesity. The weight management must be expected to produce a significant improvement of the Covered Person's condition within a six (6) month period. For the purposes of this provision, "significant improvement" means a reduction of weight by 10% the first 6 months, with a continued 10% reduction every 6 months from the adjusted baseline weight or a minimum of 1 to 2 pounds per week. The need to continue the care and regimen established must be documented in writing by the Physician for each six (6) month period. Benefits will terminate when the Covered Person's body mass index (BMI) has decreased below 30.

**Bariatric surgery (only Roux-En-Y Gastric Bypass and Laparoscopic adjustable gastric banding [Lap-Band] procedure):** Only procedures meeting the criteria established by the Utilization Review Coordinator will be considered a Covered Charge under this Plan. Charges must be preauthorized by the Utilization Review Coordinator. The Covered Person must and meet Medically Necessary criteria established by the Utilization Review Coordinator. The surgeon must be designated as a Center of Excellence by the American Society of Metabolic & Bariatric Surgery. The Covered Person must have failed previous attempts to reduce weight under a Physician-monitored weight-loss program as described above for a minimum of one year in the two-year period immediately preceding the date the Physician requests benefit authorization. The Covered Person's BMI must be 40 or greater in conjunction with at least 1 of the following co-morbidities: hypertension uncontrolled by medical treatment, sleep apnea, coronary artery disease and diabetes mellitus. Physician documentation is required which indicates the Covered Person has been Morbidly Obese (as defined by the plan) for a minimum of 5 years immediately preceding surgery.

**Panniculectomy surgery:** Surgical removal of redundant skin folds is generally considered a cosmetic procedure. However, in order to be eligible for this surgery post weight-loss, the Covered Person must meet Medically Necessary criteria utilized by the Utilization Review Coordinator and must participate in the follow-up program, as appropriate, which may include an aftercare support group and Physician visits.

Coverage of Well Newborn Nursery/Physician Care.

**Charges for Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Customary Allowance for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child. Charges for a newborn child who is injured or ill will be applied toward the Plan of the newborn.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. The Covered Person is still responsible for the Precertification process. (Refer to the Cost Management Section.)

The 48- or 96-hour inpatient stay begins at the time the delivery occurs in the Hospital. For deliveries occurring outside of the Hospital, the stay begins at the time the mother and/or newborn are admitted as an inpatient to a Hospital.

**Charges for Routine Physician Care.** The benefit is limited to the Usual and Customary Allowance made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Circumcision is considered under this benefit if performed during the initial Hospital confinement. Otherwise, it will be considered an eligible expense under Physician Services (refer to Schedule of Benefits) up to the second birthday of the Dependent Child or within 2 years of legal adoption. Thereafter, it will not be considered an eligible charge unless Medically Necessary (refer to Physician Services in the Schedule of Benefits for benefits).

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. Charges for a newborn child who is injured or ill will be applied toward the Plan of the newborn.

*Charges associated with the initial purchase of a wig following care and treatment related to alopecia areata or scalp infection or as a result of treatment of a covered medical condition (e.g., chemotherapy for cancer). Benefits are subject to the limits as described in the Schedule of Benefits.*

*X-rays, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.*
PREADMISSION CERTIFICATION (Inpatient hospitalizations)

AUTHORIZATION IS NOT A GUARANTEE THAT ALL CHARGES ARE COVERED.

Preadmission Certification (also referred to as Precertification) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Precertification Nurse will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to a network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

Precertification Procedures

The Covered Person or the Physician must call MPI Care (Utilization Review Coordinator) at (417) 886-6886 or (800) 777-9087 for precertification as follows:

Scheduled Inpatient hospitalization - Precertify at the earliest time prior to the admission of a scheduled Hospital stay. When the Covered Person or Physician notifies the Utilization Review (UR) Coordinator of a scheduled hospitalization, the UR Coordinator will then determine the length of stay based upon diagnosis, appropriateness of services and the Physician's plan of treatment. The UR Coordinator also assures that reasonable alternatives to inpatient care are considered, including outpatient treatment and preadmission testing. Request for second surgical opinion may also be made at that time. For every approved admission, a target length of stay will be assigned by the UR Coordinator, based upon length of stay norms for the geographical region. A preadmission certification letter will be sent to notify the Covered Person, Hospital and attending Physician of the assigned length of stay.

Unscheduled, non-emergent Inpatient hospitalization - Precertify within 48 hours after a weekday admission or within 72 hours after an admission on a weekend or legal holiday. Unscheduled admission means an admission for treatment of an Injury or Illness that requires immediate inpatient treatment which is Medically Necessary and cannot be reasonably provided on an outpatient basis.

Emergency Inpatient hospitalization - Precertify within 48 hours after a weekday admission or within 72 hours after an admission on a weekend or legal holiday. Emergency admission means an admission for a Life-threatening medical condition or a condition for which the lack of immediate treatment would cause permanent disability.

Precertification Penalties

Failure to follow the precertification procedure as described above will reduce reimbursement received from the Plan.

If precertification is not obtained as explained in this section, a penalty may be applied. (Refer to the first page of the Schedule of Benefits for details.) Any reduced reimbursement due to failure to follow the precertification procedures will not accrue toward the 100% maximum out-of-pocket (deductible plus coinsurance) payment as indicated in the Schedule of Benefits.

**Exception:** A Plan may not, under federal law, require that a Physician or other health care provider obtain precertification from the Plan for prescribing a maternity length of stay of up to 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. However, to use certain providers or facilities, or to reduce the out-of-pocket costs, the Covered Person is still required to obtain precertification for the Hospital stay. If the stay is not precertified, the individual is responsible for the amount indicated in Precertification Penalties above. A Covered Person will not be denied the Hospital stay granted under State or Federal law. For more information on precertification, contact the Plan Administrator or Claims Supervisor.

EXTENDED HOSPITAL STAYS

Once a Hospital stay begins, whether it is a non-emergency or emergency, if the stay is expected to exceed the number of days precertified, the Covered Person or the Physician must contact the Utilization Review Coordinator to request an extension of the length of stay.
EFFECTS OF PREADMISSION CERTIFICATION ON BENEFITS

Authorization is not a guarantee that all charges are covered.

If any part of a Hospital stay is not precertified, the penalty amount shown in the Precertification Penalties section and the Schedule of Benefits may be applied. No part of the penalty will be applied towards the deductible amount shown in the Schedule of Benefits or the maximum out-of-pocket expense limitation.

A Hospital stay is not precertified if:

1. Precertification is not obtained prior to admission;
2. The type of treatment, admitting Physician or the Hospital differs from the precertified treatment, Physician or Hospital.

CONCURRENT REVIEW

The purpose of concurrent review is to continually evaluate the Covered Person's progress toward the treatment goal and the patient's ability to function in a non-acute environment and to facilitate timely discharge as appropriate.

PREAUTHORIZATION AND UTILIZATION REVIEW

Preauthorization means the review of services prior to their being rendered to determine if the services are eligible under the Plan. If preauthorization is not obtained as described in this section, benefit reimbursement may be delayed while awaiting further information from the Physician or Covered Person. The Utilization Review Coordinator will consider the following, among other things, in making this decision: medical services, treatments and/or supplies are covered under this Plan; meet standards of care; are Medically Necessary; are ordered by a Physician; and are not Experimental/Investigational or otherwise excluded by this Plan.

Services Subject to Preauthorization and Utilization Review:

Authorization is not a guarantee that all charges are covered.

It is recommended that The Covered Person or the Physician should call the Utilization Review Coordinator for preauthorization of the following services and any other services identified with an "*" on the Medical Schedule of Benefit. (Refer to the ID card or the last page of this book for the phone number):

- Home Health Care (including all IV Infusion therapies)
- Durable Medical Equipment (greater than $200 purchase value)
- Physical, speech and occupational therapy
- Cardiac and pulmonary rehabilitation therapy
- Obesity Treatment
- Private Duty Nursing
- Orthotics/Prosthetics (including cochlear implants)
- IV Infusion (Outpatient or Physician's office, except for chemotherapy)
- Stereotactic radiosurgery. (This service must be preauthorized or it will not be considered a Covered Charge under this Plan. The Utilization Review Coordinator will review the cases for Medical Necessity and applicable exclusions. A second opinion may be required.)
- Non-Network Provider services when In-Network Providers are available

MEDICAL CASE MANAGEMENT

The purpose of Medical Case Management is to identify potentially high-dollar claims as a result of serious illnesses, accidents or other circumstances and to coordinate the highest quality care in the most appropriate, cost-effective setting. The interest of the Covered Person is always primary in this program. The Covered Person receives the type of care required and the available benefits are used more effectively. Large Case Management is more than a cost containment provision. It requires in-depth involvement between the Case Manager, the provider and the Covered Person. The Covered Person, family and the attending Physician must be in agreement for any form of alternative medical care.

The Medical Case Management firm may recommend coverage for services or equipment that is not normally provided to the Covered Person under the Plan. In these instances, exceptions may be made by the Plan Administrator to cover these services or equipment that are recommended. The alternative benefits shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall
not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Services provided by Medical Case Management are:

**Continued Hospital Stay Review.** The Covered Person may be hospitalized longer than Medically Necessary. Substantial savings can be achieved by reviewing the Covered Person's condition and treatment based on established medical criteria. Inappropriate treatment may be identified and discontinued.

**Discharge Planning.** Careful advance planning can ease the Covered Person's transfer from an acute-care facility to a less costly and more suitable facility such as a nursing home, rehabilitation center or the Covered Person's own home. It ensures that the benefits or early discharge are not outweighed by the need for a return to the Hospital at a later date for corrective and more costly treatment.

**Home Health Care Coordination.** Home health care involves coordination of required medical treatment and evaluation of the appropriate required level of care by the Medical Case Management firm. Patient/family counseling would be considered a covered expense in connection with these services, where applicable.

The following types of claim situations may have the potential for Medical Case Management:

1. Severe trauma (head injuries, extensive burns, spinal cord injuries, multiple fractures, etc.);
2. Coma (any cause);
3. Neonatal (prematurity, birth injuries, congenital deformities, profound retardation, etc.);
4. Organ transplants; or
5. Any claim where it appears that there will be extensive inpatient and/or outpatient charges, particularly for a long duration.

Note: Medical Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

**SECOND AND/OR THIRD OPINION PROGRAM**

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or is not Life-threatening in nature. Refer to the Schedule of Benefits. These benefits also apply if the second opinion is requested by the Utilization Review Coordinator. If the second opinion is for non-surgical services, approval is required by the Utilization Review Coordinator for coverage under this benefit.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

<table>
<thead>
<tr>
<th>Appendectomy</th>
<th>Hernia surgery</th>
<th>Spinal surgery</th>
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<tbody>
<tr>
<td>Cataract surgery</td>
<td>Hysterectomy</td>
<td>Surgery to knee, shoulder, elbow or toe</td>
</tr>
<tr>
<td>Cholecystectomy (gall bladder removal)</td>
<td>Mastectomy surgery</td>
<td>Tonsillectomy and adenoidecomy</td>
</tr>
<tr>
<td>Deviated septum (nose surgery)</td>
<td>Prostate surgery</td>
<td>Tympanotomy (inner ear)</td>
</tr>
<tr>
<td>Hemmorhoidectomy</td>
<td>Salpingo-oophorectomy (removal of tubes/ovaries)</td>
<td>Varicose vein ligation</td>
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</tbody>
</table>
The following terms have special meanings and when used in this Plan will be capitalized.

**Accident** an external event that is sudden, violent and unforeseen and exact as to time and place.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis or has been determined to be full-time based on Hours of Service during the Initial Measurement Period or Standard Measurement Period, as applicable. For this purpose, an Employee shall be deemed to be actively employed on the date his or her coverage would otherwise commence if the Employee is absent from work due to a medical condition (including both physical and mental Illnesses).

**Actively At Work** means the active expenditure of time and energy in the service of the University. An Active Employee shall be deemed actively at work on each day of a regular paid vacation, or on a regular non-working day on which he/she is not totally disabled, providing he/she was actively at work on the last preceding regular work day.

**Activities of Daily Living (ADLs)** are the things we normally do for self-care, work, homemaking and leisure. Health professionals routinely refer to the ability or inability to perform ADLs as a measurement of the functional status of a person. This measurement is useful for assessing the elderly, the mentally ill, those with chronic diseases, and others to evaluate the type of health care services needed.

**Basic ADLs** (The basic activities of daily living consist of these self-care tasks): Bathing/showering; dressing/undressing; eating; transferring from bed to chair, and back; toileting and functional mobility.

**Instrumental ADLs** [Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning, but they let an individual live independently in a community] Doing light housework; preparing meals; taking medications; shopping for groceries or clothes; using the telephone; managing money; and using technology.

Occupational therapists also evaluate IADLs when completing patient assessments. These include 11 areas of IADLs that are generally optional in nature and can be delegated to others: care of others (including selecting and supervising caregivers); care of pets; child rearing; use of communication devices; community mobility; financial management; health management and maintenance; home establishment and management; meal preparation and cleanup; Safety procedures and emergency responses; and shopping.

**Allowed Amount** is the amount on which the Plan will base its payment of benefits for Covered Charges, as shown in the Schedule of Benefits. For network providers or other providers who have agreed to a contracted or discounted rate, the Allowed Amount will be the lesser of the billed amount or network (or other) contracted rate. For non-network providers, the Allowed Amount will be limited to the lesser of the billed amount or Usual and Customary Allowance for the covered service. All considered charges must also be Reasonable (as defined in this Plan) and never be allowed at a rate greater than billed charges.

**Ambulette Service** is usually a van equipped with a wheelchair lift and other safety equipment. It is used in non-emergency transportation for wheelchair bound, physically challenged, or elderly patients. They are often used to transport dialysis, radiation, and chemotherapy patients to and from treatment or to transfer patients to and from Hospital, home or nursing facilities. They do not meet the definition of a professional ambulance.

**Amendment** means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

**Applied Behavior Analysis (ABA)** is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

Practice of ABA is the application of the principle, methods and procedures of the experimental analysis of behavior and applied behavior analysis (including principles of operant and respondent learning) to assess and improve socially important human behaviors. It included, but is not limited to, applications of those principles, methods, and procedures to:

1. the design, implementation, evaluation, and modification of treatment programs to change behavior of individuals;
(2) the design, implementation, evaluation, and modification of treatment programs to change behavior of 
groups; and
(3) Consultation to individuals and organizations.

ABA does not include physical therapy, occupational therapy, speech therapy or cognitive therapies or 
psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, 
psychotherapy, sex therapy, psychoanalysis, hypnotherapy, family therapy and long-term counseling as treatment modalities.

Audiologist means a person who:

(1) is licensed as such by the Missouri Board of Healing Arts.

(2) is certified as such by the American Speech-Language and Hearing Association.

Autism Spectrum Disorder (ASD) is a neurobiological disorder, an Illness of the nervous system, which includes 
Autistic Disorder, Asperger’s Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett’s 
Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and 
Statistical Manual of Mental Disorders of the American Psychiatric Association.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Benefit Percentage means that portion of eligible expenses to be paid by the Plan in accordance with 
the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in 
excess of the annual deductible which are to be paid by the Covered Person.

Benefit Year means a period of time commencing with the effective date of this Plan or the Plan Anniversary, and 
terminating on the date of the next succeeding Plan Anniversary.

Bilateral Surgical Procedure shall mean any surgical procedure performed on any body part or paired organ 
whose right and left halves are mirror images of each other or in which a median longitudinal section divides the 
organ into equivalent right and left halves or on any pair of limbs. Surgery on both halves or both limbs is 
performed during the same operative session and may involve one (1) or two (2) surgical incisions.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a 
Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and 
operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide 
care under the full-time supervision of a Physician or a licensed nurse-midwife. The licensed nurse-midwife must 
have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop 
complications or require pre- or post-delivery confinement and a written collaborative agreement with an 
appropriately licensed Physician.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Children means natural children, step-children, adopted children or children placed with a covered Participant in 
anticipation of adoption and if the Participant is legal guardian.

Claims Review Committee means the three-member University committee appointed by the Vice President for 
Administrative Services with authority to review and consider Participants’ appeals of denied claims. The 
Committee shall have no power to alter or amend the provisions of the Plan.

Claims Supervisor means the persons or firm employed by the University to provide employee benefit 
administration services to the University in connection with the operation of the Plan and any other functions, 
including processing and payment of claims.

Close Relative means the spouse, Sponsored Dependent, parent, brother, sister, child, spouse or Sponsored 
Dependent’s parent of the Covered Person.
COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means the percentage the Covered Person is responsible for after the Deductible is satisfied or as required when the Deductible is waived. Refer to the Schedule of Benefits for the Coinsurance maximum and when it is required.

Copayment means the amount the Covered Person is responsible to pay for a Prescription Drug or other service as indicated in the Schedule of Benefits (Medical or Prescription) before the Plan pays. A Copayment can be either a fixed dollar or a percentage of the Allowed Charge.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements. Cosmetic Surgery is typically surgery that changes:
- The texture or appearance of the skin; or
- The relative size or position of any body part
when such surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

Cost Containment Penalties are structured by the Plan Administrator to encourage the Covered Person's compliance with the policies and procedures. These policies and procedures are designed to maximize benefits and lower costs for both the member and the plan. Penalty amounts do not accrue towards the individual or family maximum out-of-pocket amounts. The following are examples of penalties that can be assessed: benefit reduction for not properly pre-certifying an Inpatient stay; additional deductible for emergency room or Inpatient stays; charges over the Usual and Customary allowance or network contract allowance for out-of-network services; higher patient deductible and/or coinsurance for out-of-network services; day/visit/dollar limits for certain services; other provisions as stated in the Plan.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Active Employee, Retired Employee, Surviving Spouse of a Retired Employee, Sponsored Dependent or COBRA Continuant, or the eligible Dependent of an Active Employee, Retired Employee, Surviving Spouse of a Retired Employee, or COBRA Continuant who is covered under this Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible means a specified dollar amount of covered expenses which must be incurred during a benefit period before any other covered expenses can be considered for payment according to the Schedule of Benefits.

Dentist means only a legally qualified dentist or physician authorized by his/her license to perform, at the time and place involved, the particular dental procedure rendered by him/her.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Dependent means Spouse, Sponsored Dependent, Child or Totally Disabled Child as described in the Eligibility section of this document.

Dependent Coverage means eligibility under the terms of the Plan for benefits payable as a consequence of eligible expenses incurred for an illness or injury of a dependent.

Developmental Disability means a child’s substantial handicap which:

1. results from mental retardation, cerebral palsy, epilepsy or other neurological disorders; and
2. is diagnosed by a Physician as a permanent or long-term, continuing condition.

Diagnostic X-Ray and Laboratory charges means covered charges for X-ray and laboratory examinations performed.
Disability and Disabled means the Covered Person's inability because of sickness or injury to work at his/her normal job.

Disability Due to Injury means Disability that:

1. Occurs solely and directly because of an accidental injury; and
2. Begins within thirty (30) days of the accident.

Disability Due to Sickness means Disability that:

1. Occurs directly or indirectly because of disease, mental disorder, nervous disorder, alcoholism or drug abuse; or
2. Is not a Disability Due to Injury.

Elective Surgical Procedure means a surgical procedure which is not considered an emergency and which may be avoided without undue risk to the individual.

Eligible Class includes the classes as described in the Eligibility section of this document.

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention will result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any body organ or part.

Examples of these conditions are heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions. The Utilization Review Coordinator or Claims Supervisor will assess emergency treatment/admissions to a Non-Networkparticipating Provider to determine if it meets the exception criteria. The exception criteria will be assessed on a case-by-case basis, taking into consideration such things as the individual's medical history, current illness/injury and the circumstances (consciousness, EMT/ambulance services, etc.) surrounding the current illness/injury in relation to the accessibility/location of other Networkparticipating Providers.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/employer relationship and meets the eligibility requirements outlined in "Eligibility Requirements for Participant Coverage" section. The following persons are specifically excluded from the Plan: persons employed as leased employees or independent contractors; persons who are classified by the Employer as temporary workers; and persons covered by a collective bargaining agreement unless the Employer and collective bargaining unit have agreed to participation under the Plan. For purposes of the foregoing, the Employer's employment classification of an individual shall be binding and controlling for all purposes and shall apply regardless of any contrary classification of such person by any other person or entity, including without limitation, the Internal Revenue Service, the Department of Labor, or a court of competent jurisdiction.

Employer is Missouri State University.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:
(1) 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

(2) 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

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, 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

However, routine patient care costs for a phase III clinical trial for prevention, early detection and treatment of cancer will be covered according to Missouri Revised Statutes when the trial is approved or funded by one of the following entities:

(a) One of the National Institutes of Health (NIH),

(b) An NIH cooperative group or center,

(c) The FDA in the form of an investigational new drug application,

(d) The federal Department of Veterans’ Affairs or Defense,

(e) An institutional review board in that state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46), or

(f) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

However, routine patient care costs for a phase II clinical trial for prevention, early detection and treatment of cancer will be covered according to Missouri Revised Statutes if:

(a) The trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(b) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

“Cooperative group” is a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating with the group, including the NCI Clinical Cooperative Group and the NDI Community Clinical Oncology program.

“Routine patient care costs” shall include coverage for reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigation item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; or

(4) 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.

Reliable Evidence shall mean 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
substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Family Unit** is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

**Free Standing Surgical Facility** means an institution which meets all of the following requirements:

1. Has a medical staff of physicians, nurses and licensed anesthesiologist; and
2. Maintains at least two (2) operating rooms and one recovery room; and
3. Maintains diagnostic laboratory and X-ray facilities; and
4. Has equipment for emergency care; and
5. Has a blood supply; and
6. Maintains medical records; and
7. Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an in-patient basis; and
8. Is licensed in accordance with laws of the appropriate legally authorized agency.

**Generic** drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Genetic Information** means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

**Hearing Loss or Impairment** means a disorder which is within the scope of the license or certification of an audiologist.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.
Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Healthcare Facilities Accreditation Program (If the Hospital is not accredited by one of the previous entities but has received accreditation through an entity recognized by CMS as an alternative to JCAHO, then this Plan will also recognize the facility as accredited.); it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises. If the Plan has a network that credentials their providers for participation in the network, the facility will be considered eligible regardless of the accreditation or Medicare status required in this definition.

Hospital Miscellaneous Expenses means the actual charges made by a hospital in its own behalf for services and supplies rendered to the Covered Person which are medically necessary for the treatment of such Covered Person. Hospital miscellaneous expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the hospital or otherwise.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incidental means requiring unplanned treatment, care or services for a non-emergent Illness while outside the network area. For example, requiring Physician services for acute sinusitis while traveling outside the network area.

Incurred Expense means those services and supplies rendered to a Covered Person. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided.

Injury means an accidental physical injury to the body caused by unexpected external means.

Inpatient means the classification of a Covered Person when that Covered Person is admitted to a hospital, hospice, or convalescent facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Covered Person who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period. (see below).

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child under the age of 18. (Refer to the Eligibility section of this document for eligibility requirements including coverage beyond this age limit.) For the purposes of this Plan, Legal Guardianship must be established by a court of law.

Legally Separated (Legal Separation) means, for purposes of this Plan, a legally married couple who have successfully petitioned a court to recognize their separation.

Licensed Practical Nurse means an individual who has received specialized nursing training and practical nursing experiences, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Life Threatening is defined as any serious illness or injury that necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure. Examples: burns, loss of organs, loss of limbs, blindness, heart attack, stroke and excessive uncontrolled bleeding through open wounds.
Maintenance programs is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. These are the repetitive services required to maintain function and generally do not involve complex and sophisticated occupational/physical/speech therapy procedures; and consequently, the judgment and skill of a qualified therapist are not required for safety or effectiveness.

However, in certain instances, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition if the maintenance program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service and would be a covered expense under the Plan.

Medicaid means the health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

Medical Care shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness of Injury.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Case Management means the development of alternative treatment plans for Covered Persons that meet the medical needs of the person and are more cost effective than standard treatment plans.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the “Health Insurance for the Aged and Disabled” program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity/Severe Clinical Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by 100 or more pounds over normal weight (by insurance underwriting standards) or the body mass index (BMI) is 35 or greater for a person of the same height, age and mobility as the Covered Person.

Multiple Surgical Procedures (shall mean surgical procedures which are performed during the same operative session and which are not incidental or secondary to one (1) primary procedure for which the operative session is undertaken. An “incidental procedure” is a procedure which is not Medically Necessary at the time it is performed. A “secondary procedure” is a procedure which is not part of the primary procedure for which the operative session is undertaken.

Network Physician shall mean a duly licensed Physician under contract with any of the Plan’s contracted Networks.

Network Provider shall mean any Hospital, Physician, pPharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the Plan’s contracted Networks.

Newborn means an infant from the date of his/her birth until the initial hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

Never Events are occurrences that should never happen; e.g., surgery on the wrong body part or death due to contaminated drugs or devices. The criteria for inclusion on the Never Events list include: i) adverse consequence of care results in unintended injury or illness; ii) indicative of a problem in a health facility's safety systems; and iii)
important for public credibility or public accountability. Refer to www.cms.hhs.gov for the full listing of Never Events.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Nonresidential Treatment Facility** is a facility that can provide medical and other services for the treatment of Substance Abuse to individuals who do not require inpatient status and are free from acute physical and mental complications. The facility must maintain an organized program of treatment that may be limited to less than 12 hours per day and not be available 7 days a week. The facility must be certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.

**Orthotic Appliance** means an external device intended to correct any defect in form or function of the human body.

**Other Facility Provider** shall mean any of the following: Outpatient Care Facility, Substance Abuse Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric day treatment facility, psychiatric hospital, Hospice, Extended Care Facility, or rehabilitation hospital, which is licensed as such in the jurisdiction in which it is located.

**Other Professional Provider** or **Professional Provider** shall mean the following persons or practitioners, including Physicians, acting within the scope of such provider’s license which is certified and licensed in the jurisdiction in which the services are provided:

<table>
<thead>
<tr>
<th>Audiologist</th>
<th>Licensed Practical Nurse Occupational Therapist</th>
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<tr>
<td>Anesthetist</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>Certified Athletic Trainers</td>
<td>Physical Therapist</td>
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<tr>
<td>Chiropractor</td>
<td>Physiotherapist</td>
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<tr>
<td>Clinical Social Worker</td>
<td>Psychologist</td>
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<td>Dentist</td>
<td>Registered Nurse</td>
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<tr>
<td>Emergency Medical Technician</td>
<td>Respiratory Therapist</td>
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<tr>
<td>Independent Laboratory Technician</td>
<td>Speech – Language Pathologist</td>
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<td>Midwife</td>
<td>Vocational Nurse</td>
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<tr>
<td>Licensed Practical Nurse Occupational Therapist</td>
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Any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his/her license.

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

**Outpatient Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Partial Hospitalization** is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse condition when there is Reasonable expectation for improvement or to maintain a patient’s functional level and prevent relapse. This program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the stay in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

**Participant** means an Active Employee, Retired Employee, or the surviving spouse of a Retired Employee.

**Participating or Network Physician** shall mean a duly licensed Physician under contract with any of the Plan's contracted Networks.

**Participating or Network Provider** shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the Plan's contracted Networks.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.
Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), and Doctor of Podiatry (D.P.M.), and Doctor of Chiropractic (D.C.).

Plan means Missouri State University Group Medical Plan, which is a benefits plan for certain Employees of Missouri State University and is described in this document.

Plan Administrator means Missouri State University which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year. (Refer to General Plan Provisions.)

Pre-Admission Testing is pre-operative or pre-procedural diagnostic screening required to determine the Covered Person’s health status prior to a scheduled medical or surgical procedure on an Inpatient or Outpatient basis.

Predetermination of Benefits can be requested in writing by the provider or the Covered Person for services that normally do not require precertification or preauthorization of benefits.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Care ("Well Adult" and "Well Child" care) is care by a Physician that is not for an Injury or Sickness. Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Examinations, screenings, tests, items or services are not covered under the Preventive Care benefit when such services are diagnostic, investigational or experimental, as determined by the Plan. Services for diagnostic reasons may be covered under other applicable plan benefits.

The Plan will use reasonable medical management techniques to control costs of the Preventive Care benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Care services, which must be satisfied in order to obtain payment under the Preventive Care benefit. Covered Charges under Medical Benefits for adults and children are payable as described in the Schedule of Benefits is intended to prevent the onset of an illness or a disease or to provide an early diagnosis of a medical condition which is not known or reasonably suspected by the Physician or patient. Preventive care includes routine, periodic or annual examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific injury, illness or pregnancy-related condition as determined appropriate by the Physician in consultation with the patient.

Psychiatric Care (also known as psychoanalytic care) means treatment for a mental illness or disorder, a functional nervous disorder, alcoholism or drug addiction.

Psychologist means an individual who is licensed or certified as a clinical psychologist. Where no license or certification exists, the term "Psychologist" means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he/she is:

1. Operating within the scope of his/her license; and
2. Performing a service for which benefits are provided under this Plan when performed by a Psychologist.

Reasonable means not excessive or extreme as determined by the Plan Administrator. See also Usual & Customary Allowance. If it is determined that a charge is not Reasonable, but services are still eligible, the allowance will be based upon an estimated 150% of the Medicare allowable, regardless of previously negotiated or contracted rates.

Reasonable and Necessary is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. To be considered Reasonable and Necessary, the following conditions must be met:

1. The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition.
The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist or under his/her supervision. Services which do not require the performance or supervision of a therapist are not considered Reasonable or necessary services, even if they are performed or supervised by a therapist.

The development, implementation, management, and evaluation of a patient care plan constitute skilled therapy services when, because of the patient’s condition, those activities require the skills of a therapist to meet the patient’s needs, promote recovery, and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, those Reasonable and necessary management and evaluation services may be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

While a patient’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, the key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.

There must be an expectation that the patient’s condition will improve significantly in a Reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

The amount, frequency, and duration of the services must be Reasonable.

Registered Graduate Nurse means an individual who has received specialized nurses’ training and is authorized to use the designation of “R.N.”, and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Residential Treatment Facility meets the following criteria:

1. Operates legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
2. Is certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.
3. Is primarily engaged in providing diagnostic and therapeutic services for treatment of Mental Disorders and Substance Abuse on an inpatient basis; maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients.
4. Has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff.
5. Operates on a 24-hour basis, 7 days a week under an organized program.

Restorative Therapy is a term used in conjunction with occupational, physical, speech or other rehabilitative therapy which must, among other things, be Reasonable and Necessary to the treatment of the individual’s Illness or Injury. If an individual’s expected restoration potential would be insignificant in relation to the extent and duration of the therapy services required to achieve such potential, the therapy would not be considered Reasonable and Necessary. In addition, there must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time. However, if at any point in the treatment of an illness/injury it is determined that the expectations will not materialize, the services will no longer be considered Reasonable and Necessary and they would, therefore, be excluded from coverage.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Room and Board means all charges by whatever name called which are made by a hospital, hospice, or skilled nursing facility as a condition of occupancy. Such charges do not include the professional services of physicians for intensive nursing care by whatever name called.

Second Surgical Opinion means an evaluation of the need for surgery by a second doctor (or a third doctor if the opinions of the doctor recommending surgery and the second doctor are in conflict), including the doctor’s exam of the patient and diagnostic testing.

Semi-Private means a class of accommodations in a hospital or skilled nursing facility in which at least two patients’ beds are available per room.
Sickness for all Covered Persons except a Dependent daughter, means an Illness, disease or Pregnancy. Pregnancy or its complications are not covered for Dependent daughter.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare, the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialty Drugs treat multi-faceted chronic diseases. They typically require unique clinical, administration, distribution and handling requirements. They are more expensive than traditional prescriptions and there are limited generics and biosimilars available. Biosimilars are a potential future opportunity that will provide therapeutic options for already approved specialty brand drugs at potentially lower costs. A list of these drugs is available by contacting the Claims Supervisor or Pharmacy Benefit Manager as stated on your health plan ID card. Only available through network specialty Pharmacy or retail location.

Speech Loss or Speech Impairment means a communicative disorder which is within the scope of the license or certification of Speech Pathologist or Speech/language Pathologist.

Speech Pathologist or Speech/Language Pathologist means a person who:

(1) Is licensed as such by the Missouri Board of Healing Arts.

(2) Is certified by the American Speech-Language and Hearing Association.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Sponsored Dependent or Sponsored Adult Dependent shall mean the eligible employee and the other person are: (1) at least 18 years old and mentally competent; (2) have shared the same residence for at least 12 months and continue to share a residence; (3) not legally married to anyone else in any state; (4) not be related by blood to a degree of closeness that would prohibit legal marriage in the State of Missouri; (5) not be Medicare eligible; (6) not a renter, boarder or tenant; and (7) be each other's sole sponsored dependent.

Spouse shall mean the person recognized as the covered Active or Retired Employee's husband or wife legally married in one of the 50 states of the United States. The Plan Administrator may require documentation proving a legal marital relationship. (Refer to the Eligibility section of this document.)

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surviving Spouse means the person recognized as the deceased covered Retired Employee’s husband or wife legally married in one of the 50 states of the United States and who had been continuously covered since retirement as an eligible dependent of the Retired Employee prior to the death.

Terminal Illness means that a person has been diagnosed by a physician with an illness with a prognosis of six
(6) months or less to live.

**Tobacco Use Cessation Program** means a formalized program of therapy, prescribed medicines and over-the-counter (OTC) nicotine replacement therapies which is under the direction of a trained/certified therapist, counselor, healthcare provider, or Physician with the goal of ending the use of the specific tobacco product.

**Total Disability (Totally Disabled)** means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

**University** means an institution accredited in the current publication of accredited institutions of higher education. The term “University” in this document also refers to Missouri State University, the Fiduciary and Plan Administrator for benefits covered by this Plan.

**Unscheduled, non-emergent hospitalization** is the hospitalization for the treatment of an Injury or Illness that requires immediate Inpatient treatment which is Medically Necessary and cannot be reasonably provided on an Outpatient basis.

**Usual and Customary Allowance** is determined by the Plan Administrator using the following information:

1. Third Party data;
2. Contracted allowables;
3. Medicare data;
4. Historical data of Claims Supervisor;
5. Geographic region of provider;
6. Cross-section of providers in geographic areas other than where the service is provided if the service is performed less frequently or is a newer service;
7. The nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience; and/or
8. Any other available data to make the determination.
9. When Usual and Customary Allowance cannot be determined with any of the above, the Plan Administrator or its designee has the discretionary authority to decide the Reasonable allowance for the care, treatment or service.
10. Even though the Usual and Customary Allowance or network/contracted rate can be determined, the Plan Administrator or its designee has the discretionary authority in determining if the established allowance is Reasonable.

For the purposes of this section, “Reasonable” means not excessive or extreme as determined by the Plan Administrator.

The Plan will consider the actual charge billed if it is less than the Usual and Customary Allowance.

**Utilization Review Coordinator** is the person who evaluates the appropriateness, medical need and efficiency of health care services, procedures and facilities according to established criteria or guidelines (industry, Claims Supervisor or appropriate third party) and under the provisions of this Plan. Typically, the review includes new activities or decisions based upon the analysis of a case. The Coordinator performs proactive procedures (such as discharge planning, concurrent planning, precertification), clinical case appeals, proactive processes (such as concurrent clinical reviews and peer reviews), and reviews appeals introduced by the provider, payer or Covered Person. (Refer to General Plan Information section for contact information.) (Refer to General Plan Information section for contact information.)

**Waiting Period** is the time beginning on the first day of employment as a Non-variable Employee and ends at midnight on the day prior to being effective (as long as remaining eligible). Refer to the “Eligibility Requirements for Employee Coverage” section. Similarly, for a Variable Hour, Part-time, Seasonal or Ongoing Employee with a change in employment status from non-Full-time to Full-time during the Measurement Period or Stability Period, it is the time beginning on the first day of employment as a Full-time Employee and ends at midnight on the day prior to being effective (as long as remaining eligible). If earlier, coverage will be effective the 1st day of the Stability Period, if the Employee averaged 30 Hours of Service or more per week (130 Hours of Service or more in a Month) during the Measurement Period.
**Well-Baby Care** means medical treatment, services or supplies rendered to a child or a newborn solely for the purpose of health maintenance and not for the treatment of an illness or injury.
PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section of this Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

1. **Abortion.** Services, supplies, care or treatment in connection with an abortion.

2. **Alternative or complementary medicine.** Services in this category include, but are not limited to, acupuncture, acupressure, holistic medicine, homeopathy, hypnosis, aroma therapy, massage/massage therapy (unless point therapy and prior authorization is obtained from the Claims Supervisor), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology (study of the iris), auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy and electromagnetic therapy. **Acupuncture or acupressure.** Services, supplies, care or treatment for acupuncture or acupressure.

3. **Charges** for failure to keep scheduled appointments, completion of claim forms, preparation of medical reports, late payment charges or mileage costs.

4. **Complications of non-covered conditions or treatments.** Care, services or treatment required as a result of a condition not covered under the Plan (i.e., is excluded) or complications from a treatment not covered under the Plan.

5. **Correctional agency or court-ordered care.** Care provided while a Covered Person is in the custody or care of a correctional agency; or when a Covered Person receives care under the authority of a court order for services rendered as a condition of parole or probation or in lieu of other correctional action.

6. **Cosmetic reasons.** Care and treatment provided for or in connection with cosmetic procedures. Refer to the Medical Benefits Reconstructive Surgery section for information about covered expenses. Reconstructive **mammoplasty** will be covered after Medically Necessary surgery. In accordance with the Women's Health & Cancer Rights Act of 1998, the Plan will cover any necessary surgery and reconstruction of the breast on which a mastectomy has not been performed in order to produce a symmetrical appearance. There is no time limit imposed on an individual for the receipt of prosthetic devices or reconstructive surgery.

7. **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

8. **Dental Expenses.** Care, services or treatment provided for expenses incurred for dental work, unless such care is specifically covered in the Schedule of Benefits, Medical Benefits or Dental Benefits sections of this Plan.

9. **Dental Implants.** Dental implants, including any appliances and/or crowns and the surgical insertion or removal of implants. (Refer to the Medical Benefits section, “Mouth, Teeth, Gums” subsection of this Plan for exception.)

10. **Educational or vocational testing.** Services for educational or vocational testing or training; non-medical self-care or self-help training; and remedial reading and special education. (Refer to Medical Benefits for coverage of Education related to newly diagnosed conditions.)

11. **Emergency Room care.** Care, services or treatment provided in an emergency room that is not an Emergency Medical Condition.

12. **Equipment.** Services, supplies and equipment for the following: gastric electrical stimulation, hippotherapy, intestinal rehabilitation therapy, prolotherapy, recreational therapy or sensory integration therapy (SIT).

13. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Customary Allowance.

14. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac or pulmonary rehabilitation, occupational or physical therapy if covered by this Plan; charges for enrollment in a health, athletic or similar club; or charges for athletic trainers.
Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care charges for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. (Refer to "Clinical Trial" in the Medical Benefits section.) The Plan shall not deny, limit or impose additional conditions on routine patient care costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions.

Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. Accommodating Intra-Ocular Lenses used to replace the lens of the eye following cataract surgery are not covered under this Plan.

Foot and Hand care. Treatment of flat feet, corns, calluses and trimming of or treatment of fungal infections of the nails (unless needed in treatment of a metabolic or peripheral-vascular disease and authorized by the Utilization Review Coordinator). Surgical treatment of toenails is eligible if Medically Necessary. Charges for the purchase of orthopedic shoes or arch supports are not covered.

Foreign travel. Care, treatment or supplies outside of the U.S. if travel is for the sole purpose of obtaining medical services. This exclusion also applies to Prescription Drugs obtained from outside the U.S. even if travel was not required. Exception: Care, treatment or supplies related to an Emergency Medical Condition or Medically Necessary treatment of an Illness while traveling outside the U.S.

Gene Manipulation Therapy. Care, treatment or services for gene manipulation therapy.

Genetic testing. Genetic testing is not covered unless it aids diagnosing of a Covered Person with functional abnormalities or who is symptomatic of an Illness which may be inheritable and the results of the test will impact the treatment being delivered.

Government coverage. To the extent permitted by law, medical care, services and supplies which are furnished by a Hospital or facility operated by or at the direction of the United States government or any authorized agency thereof, or furnished at the expense of such government or agency, or by a Physician employed by such a Hospital or facility, unless (1) the treatment is of an emergency nature, and (2) the Covered Individual is not entitled to such treatment without charge by reason of status as a veteran or otherwise. This will also apply to services excluded under “Correctional agency or court-ordered care” listed above. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

Hair loss. Care and treatment for hair loss. Care and treatment includes wigs, hair transplants or any Prescription Drug that promises hair growth, whether or not prescribed by a Physician. However, certain Prescription Drugs with a prior authorization through the Pharmacy Benefit Manager may be approved if related to alopecia areata or scalp infection or wigs may be approved if necessary as a result of treatment of a covered medical condition (e.g., chemotherapy for cancer). (Refer to the Schedule of Benefits and Medical Benefits and Prescription Drug Benefits for coverage of wigs and medications due to specific situations, e.g. alopecia areata, scalp infections and chemotherapy treatment for benefit information).

Hearing aids and exams/assessments. Charges for services or supplies in connection with hearing aids (including external or implanted hearing aids) or exams for their fitting, except as hearing screening assessments, and hearing aid assessments. (Also, refer to “Hearing exams and hearing aids for newborns” described in the Medical Benefits of this Plan.)

Home modifications. Expenses for modification of home or living quarters due to medical disabilities.
(23256) Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(24267) Hospitalization. Charges for hospitalization when such confinement occurs primarily for: physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examination or tests not connected with the actual illness or injury.

(25) Hypnosis. Charges for hypnosis are not covered.

(2678) Illegal acts (as defined by the state statutes where the incident occurred). Charges for services received as a result of Injury or Sickness occurring directly or indirectly by engaging in a Felony, an illegal occupation, a riot or public disturbance. For purposes of this exclusion, the term “Felony” shall mean any act or series of acts that may be punishable by more than a year of imprisonment. It is not necessary that criminal charges be filed. If charges should be filed, it is not necessary that a conviction result or that a sentence of imprisonment for a term in excess of one year be imposed in order for this exclusion to apply. The Plan will review information such as the police report, eyewitness accounts and/or provider medical records to determine if a criminal Felony has occurred. Proof beyond a reasonable doubt is not required. If a crime can be categorized as both a misdemeanor and a Felony, the Plan will use its discretion in determining if this exclusion will apply. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(27289) Infertility. Care, supplies, services and treatment for infertility, including but not limited to diagnostic services, artificial insemination, other artificial methods of conception, in vitro fertilization, sexual dysfunction or a surrogate mother (even in the absence of an infertility diagnosis and whether or not the surrogate is a Covered Person acting as a surrogate mother). If the treatment of the medical condition is Medically Necessary for an indication other than the promotion of fertility, then the services will be covered.

(282930) Lost, stolen or misused appliances/DME. Charges incurred to replace lost or stolen appliances/DME or to replace or repair appliances/DME due, in whole or in part, to improper use or care (according to the manufacturer's guide on proper use).

(29301) Maintenance. Care and treatment for Maintenance.

(30312) Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

(31323) Military-related disability Illness or Injury coverage. Care in connection with a military-related disability Illness or Injury to which the Covered Person is legally entitled and for which facilities are reasonably available, to the extent permitted by law; or coverage while engaged in service with the armed forces of any international organization, nation or state.

(32334) Never Events. Services, supplies, care or treatment as a result of a Never Events.

(33345) No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

(34356) Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission. This preadmission (presurgical) day will not be covered if it is not approved through the precertification process for the surgery.

(35367) Non-Prescription Drug/Vitamins/Supplements. Charges for non-prescription drugs, vitamins and nutritional supplements unless necessary for the treatment of an Illness and is approved by the Utilization Review Coordinator. (Refer to General Plan Information for contact information.)

(36378) No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

(37389) No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(383940) Not specified as covered. Medical services, treatments and supplies which are not specified as covered under this Plan. Medical services, treatments and supplies that meet standards of care, are
Medically Necessary, are ordered by a Physician, are not Experimental/Investigational and not otherwise excluded by this Plan will be covered.

**Obesity.** Care and treatment of obesity, weight loss or dietary control. Medically Necessary charge for health problems associated with high-risk Morbid Obesity/Severe Clinical Obesity will be covered. Refer to Weight Management in the Medical Benefits section for details.

**Occupational.** Care and treatment of an Injury or Sickness that is occupational (that is, arises from work for wage or profit including self-employment) for which the Covered Person is entitled to benefits under any Workers’ Compensation or Occupational Disease Law, or any such similar law. If the Covered Person is entitled to these benefits but did not receive them due to a failure to follow that plan’s guidelines, this Plan will not consider those eligible charges. The Plan will not pay for any medical benefits related to a condition for which the Covered Person received a settlement for future medical benefits from a workers’ compensation carrier.

**Orthotics.** Replacement of orthotics will not be covered unless 1) there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 3 years). Replacement of the appliance must be preauthorized. (Refer to Cost Management Services.). The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions items Foot and Hand Care and Orthotics for further information.)

**Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, water purifiers, non-prescription room humidifiers (this exclusion is not applicable for CPAP/BIPAP humidifiers), electric heating units, orthopedic or hypoallergenic pillows and mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, hot tubs, whirlpools and exercise equipment. Compression stockings are covered with a prescription / Physician’s orders. The prescription must require measurement of the patient for proper fitting. Limit two (2) pair per year.

**Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

**Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a Covered Dependent daughter only.

**Prosthetic devices.** Certain prosthetic devices are not covered under this Plan: electrical convenience aids, either anal or urethral; implants for cosmetic or psychological reasons, penile prostheses for non-organic impotence (Depends if group covers impotence); dental appliance; remote control devices; devices employing robotics; all mechanical organs; and investigational or obsolete devices and supplies. Replacement of prostheses will not be covered unless (a) there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional or (b) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). Replacement of the device must be preauthorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer’s guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for Prosthetic devices for further information.)

**Psychoanalysis or counseling with relatives** (except if the counseling is with a covered parent on behalf of a covered minor child), unless stated otherwise in the Medical Benefits section.

**Psychological reasons.** Surgery performed for psychological or emotional reasons.

**Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person’s home or is related to the Covered Person as a Spouse, Sponsored Dependent, parent, child, brother or sister, whether the relationship is by blood or exists in law.

**Routine care.** Routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected will only be covered if the benefit is listed in the Schedule of Benefits and explained in the Medical Benefits section or required by applicable law.
(5012) **Safety devices.** Charges for safety devices such as helmets (except cranial molding helmets), shower chairs, restraints, telephone alert systems, safety eyeglasses and safety enclosure bed frames/canopies (i.e., Vail enclosures, Posey bed enclosures/canopy systems) which are used to prevent a patient from leaving their bed. These devices are not primarily medical in nature and are therefore considered not Medically Necessary.

(5423) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(5234) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(5345) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery and medical or psychiatric treatment.

(5465) **Sexual dysfunction.** Care, services or treatment for sexual dysfunction unrelated to organic disease.

(567) **Shock wave treatment.** Care, services or treatment for extracorporeal shock wave treatment for plantar fasciitis and other musculoskeletal conditions.

(578) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(589) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

(57560) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

(6061) **Vision therapy.** Charges for vision therapy except as explained in the Medical Benefits section. It is not covered for learning / reading disabilities, to promote learning or for Maintenance programs.

(58612) **War.** Any loss that is due to a declared or undeclared act of war. This also applies for intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime.
PRESCRIPTION DRUG BENEFITS
(Dispensed at a Pharmacy)

Pharmacy Drug Charge

| Participating Network pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. |
| If a drug is purchased from a Non-Participating Pharmacy, or a participating Network Pharmacy when the Covered Person's ID card is not used, the Covered Person should follow the guidelines for filing the claim. The amount payable will be as shown in the Schedule of Benefits. |

Percentages Payable

| The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. |

Mail Order or Retail 90 Drug Benefit Option

| This mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). |

Covered Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This does include oral contraceptives purchased at the Pharmacy, but excludes any drugs stated as not covered under this Plan.
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. Insulin and other diabetic supplies when prescribed by a Physician.
4. Injectable drugs or any prescription directing administration by injection, such as Insulin, Imitrex, Lovenox, Betaseron, Copaxone, Avonex, Epogen, Neupogen or any other medication available to be filled as a self-injectable through the Pharmacy. If the Plan covers oral contraceptives, Depo Provera will be considered a covered expense when purchased through the Pharmacy. This list is subject to change. For the latest information on approved drugs and to obtain approval for the purchase of the drug through the Pharmacy, please contact the Pharmacy Benefit Manager as listed on the health care plan ID card.
5. Any drugs specifically allowed under the prescription benefits as established with the Pharmacy Benefit Manager that may be excluded under Medical Plan.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:
1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:
1. Administration. Any charge for the administration of a covered Prescription Drug.
2. Appetite suppressants. A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. Consumed on premises. Any drug or medicine that is consumed or administered at the place where it is dispensed.
(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal, unless prior authorized with the Utilization Review Coordinator/Claims Supervisor for treatment of an Illness or Injury.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person. A prior authorization is required for coverage of drugs related to a covered clinical trial for which the Covered Person is responsible for the cost of the drugs. (Refer to medical plan ID card for contact information.)

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless prior authorized with the Utilization Review Coordinator/Claims Supervisor.

(9) **Immunization.** Immunization agents or biological sera. However, some Immunizations have been approved for administration by certain Pharmacies. Contact the Pharmacy Benefit Manager for details. (Refer to ID card for phone number.)

(10) **Infertility.** A charge for infertility medication.

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions unless specifically allowed under the prescription benefits as established with the Pharmacy Benefit Manager.

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(15) **Non-legend drugs.** Any drug for which no prescription is required by federal or state law. These are generally referred to as "over-the-counter" items.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
**HOW TO SUBMIT A CLAIM**

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them. Benefits are provided in accordance with the terms and conditions of this Plan, as set forth in this Summary Plan Description.

**How will the Covered Person be billed for these services?**

Charges for medical services are billed by the provider at their normal rates. This is the price an individual would be charged in absence of any contractual arrangements with the provider. When contractual arrangements exist, the claim is re-priced to the discounted rate. This repricing function may either be performed by the Claims Supervisor or a PPO Network.

Typically, the claim is submitted by the provider. If the patient must file a claim directly, it must be submitted to the address indicated on the ID card. Refer to the section below for information required to be submitted on the claim.

Once a Clean Claim* is received by the Claims Supervisor, it is processed and an Explanation Of Benefits (EOB) is returned to the provider and Employee (or covered dependent if directed to do so) explaining any patient responsibility and/or reimbursement to the appropriate party. Occasionally the Claims Supervisor must pend a claim to the provider or Covered Person if enough initial information is not received in order to process the charges. This can cause delays in processing.

When the Covered Person receives medical services, providers may collect any applicable co-payments, deductibles or co-insurance amounts for covered services, or for services not covered by the Plan, at the time service is rendered. Billing and payment arrangements are between the Covered Person and the provider.

If the Covered Person does not receive timely notice of the determination of the health claim, he/she should contact the Claims Supervisor directly at the phone number listed on the ID card to verify receipt of the claim and/or the provider to make sure the claim was filed correctly.

**"Clean Claim"** means a claim void of any material errors, omissions of pertinent information, coordination of benefits issues, and any liability issues, as determined by the Plan Administrator. Where not otherwise specified, this Plan follows National Correct Coding Initiative for coding modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

Charges for medical services are billed by the provider at their normal rates. This is the price an individual would be charged in absence of any contractual arrangements with the provider. When contractual arrangements exist, the claim is re-priced to the discounted rate. This repricing function may either be performed by the Claims Supervisor or a PPO Network. The billed amount less any ineligible amount (including Usual and Customary Allowance), contracted discount or negotiated discount results in the Allowed Amount under this Plan. (Refer to the Schedule of Benefits for further information.)

A "Claim" is defined as any request for a Plan benefit, made by a Covered Person or by an authorized representative of a Covered Person that is filed with the Plan in accordance with the procedures described below. There are different types of Claims that may be filed under this Plan (as defined in the Claims and Appeals Timelines section below). For purposes of the appeals procedures as outlined, a Claim also includes any appeal of the Plan’s decision to retroactively rescind your coverage due to fraud or intentional misrepresentation. For purposes of this section, a Claim does NOT include any request for eligibility to participate or to change an election under the Plan. If you have a question about eligibility or enrollment, contact the Plan Administrator.

**How does the Covered Person file a claim when the provider does not do so on their behalf?**

If you visit a Network Provider, the provider will file the Claim on your behalf. Even though the network provider files on your behalf, you should check with the provider to ensure that the provider did, in fact, file the Claim on your behalf.

If you visit a Non-Network Provider, you or your authorized representative must file the Claim with the Plan at the address identified on your ID Card. You must file the Claim in accordance with the procedures described below.


2. Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
(3) If a claim or bill from the provider is not available with all the information below, have the Physician complete the provider's portion of the form if an itemized bill with diagnosis is not available.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis (ICD-9 codes)
- Type of services rendered, with diagnosis and/or procedure codes (CPT codes)
- Date of services
- Charges

(5) Send the above to the address on the ID card.

Regardless of whether a Network Provider, you or your authorized representative files the Claim, it is not possible to make a determination that benefits are payable unless the Claim constitutes a “Clean Claim”. A “Clean Claim” means a claim void of any material errors, omissions of pertinent information, coordination of benefits issues, and any liability issues, as determined by the Plan Administrator. Where not otherwise specified, this Plan follows National Correct Coding Initiative (NCCI) for coding modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in making determinations. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Supervisor within 365 days of the date charges for the service were incurred. If the Covered Person's coverage terminates, all claims must be filed within 90 days of the Covered Person's termination date. If the termination is due to death, the regular filing limit applies. The following additional filing limitations apply:

(1) Claims for Benefits for services or treatments for which a Claim Charges that were not previously submitted but related to charges for services or treatments for which a Claim has been filed are still a processed claim are considered a new claim and must be filed in the time limit above.

(2) Corrected information submitted on an initial claim determination processed claim is considered an appeal and not a newly filed claim. The filing limit will follow the appeal guidelines explained further in this section limit. Refer to the Grievance and Appeal Processed and Procedures section below.

(3) If it is not reasonably possible to submit the claim in the time limit above (i.e., if the person has primary insurance with another plan and this plan is the secondary plan, if the person is not capable of submitting the claim due to illness, including mental or physical incapacity that made it unreasonably difficult to file the claim within the specified timeframe, etc.), the filing period will be 12 months from the date of service. The Claims Supervisor will determine if it was or was not reasonably possible for the claim to be submitted within the time limit above.

(4) If there are complications in the filing of claims due to the person having primary insurance with another plan and this plan is the secondary plan, the filing period will be continue to be 12 months from the date of service.

(5) If the Plan should terminate, all claims must be filed within 30 days of the Plan's termination date. The Plan Administrator will determine the length of time for claims to be filed following the plan's termination date. The Employee will be notified of the filing limit so appropriate follow-up may be performed with providers regarding outstanding claims. The time period typically allowed for the filing of claims is 30-90 days from the Plan's termination date.

If you do not receive timely notice of the determination of your Claim (as described below), please contact the Claim Supervisor directly at the phone number listed on your ID card to verify receipt of the claim. You may also contact the provider to make sure the claim was filed correctly.
NOTE: Benefits are based on the Plan’s provisions at the time the services or treatments were provided, charges were incurred.

PROCESSING OF THE FILED CLAIM

The Claims Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion. Every effort will be made to process claims as quickly as possible. Although more complicated claims may take longer, most claims are processed within fourteen (14) days or less from the date they are received by the Claims Supervisor. The Participant will receive an Explanation of Benefits (EOB) form which will indicate what services were paid for, how much was paid, who was paid, when payment was made, and why payment for some services was not made or made only in part.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Supervisor will furnish the Participant with a written notice of this denial. This written notice may also indicate what other information, if any, would be necessary for the claim to be reconsidered.

NOTICE OF DETERMINATIONS AND CLAIM APPEALS PROCEDURE

Once the Claims Supervisor receives your timely and properly filed Claim, the Claims Supervisor will review your Claim to determine whether Benefits are payable in accordance with the terms of the Plan. The following describes the step by step process once the Claims Supervisor receives your Claim and also describes your and the Plan’s rights and obligations under the Plan with respect to appeals of any denials of your Claim.

Step 1: Notice is received from Claims Supervisor.

You will typically receive a notice from the Claims Supervisor indicating the extent to which Benefits are payable under the Plan with respect to your Claim. If your Claim is denied in whole or part, the Claims Supervisor will provide a written notice of its determination to you or your authorized representative within the timeframes set forth in the Claims and Appeals Timeline Chart in this section. If the Claim is an Urgent Care Claim, the Claims Supervisor may initially notify you of its determination orally. The Claims Supervisor may take an extension of time to make the determination for reasons beyond the Claims Supervisor’s control (e.g., your Claim is not a Clean Claim). If an extension is needed, the Claims Supervisor will notify you in writing (oral notice may be provided if the Claim is an Urgent Care Claim) within the timeframes identified in the chart below. If the reason for the extension is that you need to provide additional information in order for the Claims Supervisor to make a determination, you will be afforded the opportunity to provide the missing information prior to the date set forth in the extension notice, which will be no less than 45 days from the date you receive the extension request. The Claims Supervisor’s time period for making a determination is suspended until the date that you provide the information or the end of the information gathering period, whichever is earlier.

If a claim is wholly or partially denied, the Claims Supervisor will inform the Participant in writing of the reason(s) for denial, either in an Explanation of Benefits (EOB) form or a letter. The notice of denial will contain the following information:

1. The specific reason or reasons for denial of the claim.
2. A specific reference to the pertinent Plan provision(s) upon which the denial is based.
3. A description of any additional materials or information required of the Participant in order to perfect reconsider the claim, why the information is necessary, and your time limit for submitting the information.
4. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge.
5. If the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request, and
6. If the claim was an Urgent Care Claim, a description of the expedited appeals process. The notice
may be provided to you orally; however, a written or electronic notification will be sent to you no later than three days after the oral notification.

(7) Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).

(8) An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).

(4)(9) An explanation of the claims appeal review procedure. A statement indicating that once you have exhausted all internal claims appeals and arbitration procedures you will have the right to file suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of an appeal.

Step 2: If you disagree with the decision and you desire additional consideration, you must file a 1st level Appeal with the Claims Supervisor.

If you do not agree with the decision of the Claims Supervisor, or the Pharmacy Benefit Manager (PBM) in the case of prescriptions drugs filled through a Pharmacy, and you desire additional consideration, you must submit a written appeal to the Claims Supervisor within 180 days of receiving the denial from the Claims Supervisor. If the Claim is an Urgent Care Claim, you may submit your request orally by contacting the Utilization Review Coordinator as indicated on your ID card or in the General Plan Information section of this document. There is only one level of appeal for Urgent Care Claims.

You should submit all of the information identified in the Claims Supervisor's denial letter as necessary to perfect your claim. In addition, you should include any additional information that you believe will support your Claim.

The Participant may ask the Claims Supervisor in writing for a review of the denied claim within 180 days of receipt of the notice of a denied claim. This written request for review should state the reasons why the Participant feels the claim should not have been denied. It should include any additional documents (medical records, etc.) which the Participant believes support his/her claim. The Participant may also ask additional questions or make comments and may review pertinent documents. In normal cases, the Participant will receive a final determination within sixty (60) days of the date the request for review is received by the Claims Supervisor. In special cases requiring a delay, the Participant will receive notice of a final determination no later than one hundred and twenty (120) days after the request for review is received by the Claims Supervisor.

Step 3: Notice of denial on the 1st Level Appeal.

If your 1st Level Appeal is denied in whole or part, the Claims Supervisor (or PBM as applicable) will notify you in writing of its determination within the period described in the Claims and Appeals Timeline Chart in this section. The notice of determination will include the same information as the denial notice referenced in Step #1 above.

Step 4: If you disagree with the decision and you desire additional consideration, you must file a 2nd level Appeal with the Plan Administrator.

If you do not agree with the Claims Supervisor’s 1st Level Appeal Determination, and you desire additional consideration, you must submit a written appeal to the University’s Claims Review Committee within 90 days of receipt of the Claims Supervisor’s/PBM’s 1st Appeal denial letter. There is only one level of appeal (to the Claims Supervisor) for claim involves urgent care.) For a Pre-Service Urgent Care Claim (see definition in the next section) there is only one level of appeal.

If, after considering the request for review, the Claims Supervisor’s final determination is to deny the claim, the Participant may continue the appeal procedure by requesting a review of the denied claim by the University's Claims Review Committee. Such request must be in writing and submitted within sixty (60) days of receipt of the Claims Supervisor's final determination. The written request to the Claims Review Committee must be sent to:

The Office of Human Resources
Attn: Claims Review Committee
Missouri State University
901 South National Avenue
Springfield, MO 65897

It must include:
(1) the employee's name, his or her Social Security number, the patient's name, and the pertinent circumstances related to the claim.

(2) a clear and concise explanation of the reason or reasons for appealing the denied claim.

You should submit all of the information identified in the Claims Supervisor’s denial letter (referenced in Step #1) as necessary to perfect your claim. In addition, the Participant may submit to the Claims Review Committee such additional documents which he/she believes support the claim. The Participant may review pertinent documents and submit issues and comments in writing. The Claims Review Committee may, at its discretion, invite the Participant to present his/her reason(s) for the appeal to the Committee in person. In this event, the Committee may, at its discretion, invite the Participant not less than ten (10) calendar days preparation time prior to the hearing, unless the Participant and the Claims Review Committee agree otherwise.

In performing its review of the denied claim(s), the Claims Review Committee may seek and obtain additional information and/or recommendations relevant to the denied claim(s) under review. Such additional information or recommendations may be in the form of written documents or oral statements from health care providers, claims administrators, benefits consultants, legal counsel, or other persons whose information or expertise the Committee deems necessary or desirable. Where the Committee obtains additional facts adverse to or not known to the Participant, and which the Committee determines are substantially material or dispositive with respect to the appeal, the Committee will inform the Participant to be informed of these facts or information and afford the Participant ten (10) calendar days to respond to the facts or information.

In rendering its decision(s), the Committee’s powers shall be limited in that the Committee shall have no power to alter or amend the provisions of the Plan. The Participant shall be notified in writing of the decision of the Claims Review Committee within the time frames set forth in the following Claims and Appeal Timelines Chart below sixty (60) calendar days of arriving at its decision but no later than sixty (60) calendar days from the close of the hearing. Such notification will include the specific reason(s) for the decision and reference the pertinent provision(s) of the Plan upon which the decision was based.

The decision of the Claims Review Committee shall be final and shall be implemented by the Claims Supervisor upon notification of such decision by the Claims Review Committee.

Other important information regarding your appeals:

(1) The appeal will be independent from the original determination and previous level of appeal, if applicable (e.g., the same person(s) or subordinates of the same person(s) involved in the original or in the determination of a prior level of appeal, if applicable, will not be involved in the appeal).

(2) On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.

(3) If a claim involves medical judgment, then the claims reviewer will consult with an independent health care professional during the Appeal that has expertise in the specific area involving medical judgment.

(4) You may review the claim file and present evidence and testimony at each step of the appeals process.

(5) You may request, free of charge, any new or additional evidence considered, relied upon, or generated by the plan in connection with your claim.

(6) If at any level of appeal a decision is made based on a new or additional rationale, you will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.

(7) If you wish to submit relevant documentation to be considered in reviewing your claim for appeal, it must be submitted with your claim and/or appeal.

(8) You cannot file suit in federal court until you have exhausted these appeals procedures.

(9) Please note that you must raise all issues that you wish to appeal during the Plan’s internal appeal process. If you pursue legal action to appeal your claim, you are barred from raising any issue in your lawsuit that you did not raise during the administrative claims review process.

(10) All notices from the Claims Supervisor or the Plan Administrator are deemed to be received by you within three (3) business days of the postmark date unless you provide objectively credible evidence to the contrary.
Claims and Appeals Timelines

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials. The definitions of the types of health claims are:

Pre-Service Claim. A claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you precertify hospital admissions.

Concurrent Care Claim. A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments. Concurrent Care Claim also includes a retroactive rescission of coverage due to fraud or intentional misrepresentation.

Post-Service Claim. A claim for care that has already been received.

Urgent Care Claim: A Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

- Seriously jeopardize the life of the claimant (in the view of a prudent layperson acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant’s medical condition) or
- Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant’s condition).

### Claims and Appeals Timeline Chart

**Group Health Benefit Plans**

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Initial Claims</th>
<th>If additional information is needed, claimant must provide information within...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service</td>
<td><strong>Claimant must be notified of determination as soon as possible but no later than...</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15 days after Claims Supervisor’s receipt of Claim (Including approval of Benefits)</td>
<td>One extension of 15 days, 45 days of date of extension notice</td>
</tr>
<tr>
<td>Pre-Service involving Urgent Care</td>
<td><strong>Claimant must be notified of determination as soon as possible but no later than...</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>72 hours after Claims Supervisor’s receipt of Claim (including approvals)</td>
<td>Must provide notice within 24 hours of receiving Claim if additional information is needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>48 hours. Claims Supervisor must notify claimant of determination within 48 hours of receipt of claimant’s information, N/Aa</td>
</tr>
<tr>
<td>Concurrent: To end or reduce treatment prematurely</td>
<td>Claims Supervisor will notify claimant of the decision to reduce or terminate benefits sufficiently in advance of the end date in order to allow the claimant to appeal</td>
<td>N/Aa</td>
</tr>
<tr>
<td>Concurrent: To deny your request to extend treatment</td>
<td>Treat as any other pre or post service claim.</td>
<td>One extension of 15 days, 45 days after date of extension notice</td>
</tr>
<tr>
<td>Concurrent involving Urgent Care</td>
<td>24 hours, if claimant’s request is made at least 24 hours before the date treatment is scheduled to</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Type of Claim</td>
<td>1st Level Appeal</td>
<td>2nd Level Appeal</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td><strong>Post-Service</strong></td>
<td>30 days after Claims Supervisor’s receipt of Claim</td>
<td>One extension of 15 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service</strong></td>
<td>180 days upon receipt of Claims Supervisor’s notice of determination</td>
<td>15 days after Claim Supervisor’s receipt of appeal</td>
</tr>
<tr>
<td><strong>Pre-Service involving Urgent Care</strong></td>
<td>180 days upon receipt of Claims Supervisor’s notice of determination</td>
<td>72 hours after Claims Supervisor’s receipt of appeal</td>
</tr>
<tr>
<td><strong>Concurrent: To end or reduce treatment prematurely</strong></td>
<td>180 days upon receipt of Claims Supervisor’s notice of determination</td>
<td>15 days after Claim Supervisor’s receipt of the appeal</td>
</tr>
<tr>
<td><strong>Concurrent: To deny your request to extend treatment</strong></td>
<td>180 days upon receipt of Claims Supervisor’s notice of determination</td>
<td>Treat as any other pre or post service claim</td>
</tr>
<tr>
<td><strong>Concurrent involving Urgent Care</strong></td>
<td>180 days upon receipt of Claims Supervisor’s notice of determination</td>
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<td><strong>Post-Service</strong></td>
<td>180 days upon receipt of Claims Supervisor’s notice of determination</td>
<td>30 days of Claims Supervisor’s receipt of appeal</td>
</tr>
</tbody>
</table>
COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse or Sponsored Dependent is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the COB rules (Refer to Benefit Plan Payment Order that follows) will pay as if there were no other plans involved. As a subsequent plan, this Plan will consider the allowable amount to be the lesser of:

1. what this Plan would have allowed as the primary plan; or
2. the lesser amount allowed by any preceding plan(s).

The Total payment by this Plan may be reduced so as not to exceed 100% of this total allowable amount when added to any preceding plan's reimbursement and any responsibility of the Covered Person. Should the reimbursement(s) by any preceding plan(s) exceed this total allowable, no payment will be made by this Plan.

If the primary or any other preceding plan denies a claim due to the Covered Person or provider's failure to respond to a request for more information, this Plan will not consider the charges as eligible.

If the primary or any other preceding plan denies a claim for lack of Medical Necessity, this Plan will not consider the charges as eligible. The appeals procedures under the prior plan(s) must be exhausted and the results provided to this Plan before charges will be reviewed for consideration under this Plan's benefits.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria: (1) Medically Necessary; (2) Ordered by an appropriate Physician; (3) Not excluded under the Plan; and (4) Meets the standards of care for the diagnosis.

Automobile limitations. When medical payments are available under vehicle insurance which insures the Covered Person, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. (For purposes of this section, "available" means that the insured has personal injury coverage under his/her personal automobile insurance, and applies whether the coverage is provided directly or indirectly (i.e., under a Spouse or Sponsored Dependent's or parent's auto policy). This Plan is secondary even if no claim is filed with the auto carrier. Accident claims filed with this Plan will not be considered pending receipt of the auto policy information. If the information is not provided within the requested period, the claim(s) will be denied. (Refer to the Claims Procedure section.)

This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier (only available in some states).

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:
(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B"). In no instance will the insured/Covered Person receive more than 100% of the total allowable expenses.

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are married, are living together whether or not they have ever been married or not separated or divorced, these rules will apply:

   (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

   (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

   (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

   (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

   (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

   (iv) 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 plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

   (v) If there is no court decree allocating responsibility for child’s health care expenses or health coverage or for parents who were never married to each other and not living together, the rules apply as follows as long as paternity has been established:

      The Plan of the Custodial Parent;
      The Plan of the Spouse or Sponsored Dependent of the custodial parent (if custodial parent is an Employee of the University);
      The Plan of the non-custodial parent; and then
      The Plan of the Spouse or Sponsored Dependent of the non-custodial
      The Plan of the spouse of the non-custodial parent.
If a court decree states that one of the parents is responsible for the Dependent Child’s health care expenses or health insurance coverage, that Plan is primary. This rule applies to Claim Determination Periods or Plan Years commencing after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the Dependent Child’s health care expense or health insurance coverage, the provisions of subparagraph (d) of this section shall determine the order of benefits.

For the purposes of this section:

**Custodial Parent** means the parent awarded custody by a court decree; or in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation. In the case where the parents are not married but are living together, absent any court decree directing otherwise, the Custodial Parent shall be deemed to be the mother of the child and her plan shall be the primary plan.

**Claim Determination Period** means a Calendar Year. Claim Determination Period does not include any part of the Calendar Year during which a claimant has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

If there is still a conflict after these rules (a) – (c) have been applied, the benefit plan which has covered the Covered Person for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon the benefit determination by Medicare under Parts A, B and D or this Plan, if the benefit would be less. The Covered Person must exhaust all option Medicare benefits such as reserved inpatient days before this Plan will be considered the primary payer. This Plan will always follow the standard Medicare Secondary Payer rules as may be revised from time to time.

If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

**Claims determination period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

**Facility of payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

**COORDINATION WITH MEDICARE**

**Active Employee over age 65.** If an Active Employee continues working beyond age 65, his/her health care coverage will remain in force at the prevailing employee contribution rates. In this situation, any medical claims incurred will be covered first by group coverage through the University (regardless of Medicare eligibility). Active Employees, however, are encouraged to sign up for Part A of Medicare. Before reaching his/her 65th birthday, it is suggested that the Active Employee contact the Social Security office to get more information about enrolling for Medicare coverage. Any claim amounts not paid by the University may then be submitted to Medicare for
consideration of payment, if applicable.

Also, if an Active Employee’s spouse is over age 65, the University Plan will be considered the primary payer for him/her as well, as long as he/she remains an Active Employee of the University.

**EXCEPTION TO MEDICAID**

The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.
RIGHT OF SUBROGATION AND REFUND
To the extent authorized by Section 376.433 of Missouri Revised Statutes, Missouri State University shall have the right of subrogation against third parties who are liable by reason of neglect or willful acts for causing health expenses to be paid out by Missouri State University under its Plan of self insurance. Whereas, The rights, obligations and remedies available to Missouri State University are not limited by the provisions of Section 208.215 R.S. Mo, the Recovery will apply as stated in this section.

When this provision applies.
The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a Lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This Lien shall remain in effect until the Plan is repaid in full.

While the Covered Person may receive payment of such claims pursuant to the terms of the Plan, the Covered Person shall be required to refund to the Plan all medical or dental expenses paid if the Covered Person Recovers from any other party.

The payment for benefits received by a Covered Person under the Plan when the Covered Person is also eligible for and received benefits from Medicaid shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

Payment Prior to Determination of Responsibility of a Third Party
The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Person for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party.

However, subject to the terms and conditions of this Section, the Plan may advance payment after receipt of a properly executed reimbursement agreement and consent to lien, and pay claims in accordance with the Plan of Benefits, until it is determined whether or not a third party is required to pay for those services or supplies.

By accepting an advance of benefits paid by the Plan the Covered Person jointly and severally agrees that:

1. The Plan has a priority lien against the proceeds of any such settlement, judgment, arbitration, or recovery to assure that reimbursement is promptly made; and
2. The Plan will be subrogated to every Covered Person’s right of recovery from that third party or that third party’s insurer to the extent of the Plan’s advances any benefit payments; and
3. The Covered Person(s) will, jointly and severally, reimburse the Plan out of any and all amounts paid or payable to any or all of them by any third party or that third party’s insurer to the extent of the entire amount advanced for related claims to the accident or injury by the Plan.

The Plan’s reimbursement and/or subrogation rights will include all claims, demands, actions and rights of recovery of all Covered Persons against any third party or insurer, including any Workers’ Compensation insurer or governmental agency, and will apply to the extent of any and all advance payments made or to be made by the Plan. This means that the Covered Person recognizes the Plan’s rights to 100%, first dollar priority over any and all Recoveries and/or funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, whether by judgment, settlement, arbitration award or otherwise and shall not be limited by any other characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. This priority is over any claims, including medical, non-medical or dental charges, attorney fees, or other costs and expenses associated with the enforcement of the Plan’s rights under this Right of Recovery/Subrogation
This provision expressly abrogates the "make whole" and "common fund" doctrines and similar defenses to the Plan's claims.

The Plan shall be Subrogated, and shall be entitled to Reimbursement, for any payment by a Third Party to a Covered Person for future medical expenses paid pursuant to a judgment, settlement or contract on the following bases:

1. If any amount is awarded by means of a verdict after a full and complete trial and the judgment or verdict form itemizes by separate finding or special amount awarded for future medical expenses, such amount shall be binding on the Plan and the Covered Person as the amount of future medical expenses to which the Plan is subrogated and entitled to reimbursement.

2. If there exists any contract or policy of insurance by which future medical expenses are paid (other than a policy or contract of health care, hospitalization or disability insurance issued to and in the name of such Covered Person), the Plan shall be subrogated to and entitled to reimbursement and deemed secondary or excess insurance to such contract or policy and amounts paid thereby.

3. If any amount is paid to a Covered Person by means of a settlement or general judgment or verdict which does not itemize components of damage, the Plan Administrator and the Covered Person shall agree on the amount which is attributable to future medical and dental expenses. In the event that the Plan Administrator and the Covered Person cannot agree on the amount attributable to future medical expenses, the Plan Administrator, in its sole and absolute discretion, shall determine the amount attributable to future medical expenses.

If any amount awarded under subsection (1), the total amount of future medical expenses to which the Plan is Subrogated and entitled to reimbursement shall be reduced by and, in determining the amount to which the Plan is Subrogated and entitled to reimbursement under subsection (3), consideration may be given to:

(a) the amount of proportionate or comparative fault assessed against the Covered Person which reduces the amount of total future medical expenses which are paid by the other;

(b) the amount not collectible.

In addition, in determining the amount of future medical expenses paid under subsection (3) above, consideration shall be given to the percentage of total future medical expenses paid by the one who is jointly liable with another, the other remaining liable, any discount for present value of future expenses and any discount for possibilities of incurring the claimed future medical expenses.

When any amount is paid or payable pursuant to Subsections (1), (2) or (3) above, the Covered Person shall pay all medical expenses incurred in the future for treatment of the injuries sustained for which the payments under (1), (2) or (3) were made or agreed to be made, and the Plan shall have no responsibility or liability to pay any such future medical expenses, nor shall the amount of any such payment be considered to represent a Covered Expense incurred under this Plan for purposes of satisfying any of the provisions of this Plan with respect to the Deductible or co-payment requirements, until the amount under subsection (1), (2) or (3) is fully used.

The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it advanced in accordance with the Plan of Benefits, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Persons.

However, in doing so, the Plan will not represent, or provide legal representation for, any covered individual with respect to that Covered Person's damages to the extent those damages exceed any advance on account of the Plan of Benefits.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Person against any third party or that third party’s insurer on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person’s injury or illness that resulted in the advance by the Plan.

Reimbursement and/or Subrogation Agreement
The Covered Person (or his/her representative in the case of minor child(ren) or an incapacitated Covered Person), recognizes that compliance with this section of the Plan is a condition of participating in and having payments made under this Plan, and that as such the Covered Person agrees to the provisions of this section.

The Plan’s standard administrative procedure will be to ascertain the nature of any injury to determine whether a third party could be held liable. Claims will not be paid until this determination is made. If it is determined that the
claim may be the result of a third party’s negligence, the Plan will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien.

Every Covered Person on whose behalf an advance may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan (including but not limited to the reimbursement agreement and consent to lien), and must do whatever is necessary to protect the Plan in obtaining reimbursement and/or subrogation rights. As a condition precedent to the advance payment of related claims by the Plan, all Covered Persons will, upon written request, execute a Reimbursement Agreement or Consent to Lien in a form provided by or on behalf of the Plan.

If any Covered Person does not execute any such Reimbursement Agreement or Consent to Lien for any reason, it will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan reimbursement and/or subrogation rights if the Plan, at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement and/or subrogation agreement.

Cooperation with the Plan by All Covered Persons
By accepting an advance for related claim payment, every Covered Person agrees to do nothing that will waive, compromise, diminish, release or otherwise prejudice the Plan’s Reimbursement and/or Subrogation rights.

By accepting an advance payment for related claims to an injury, every Covered Person agrees to notify and consult with the Plan Administrator or its designee before:

1. starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person’s injury that resulted in the Plan advance payment of claims; or
2. entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the Covered Person’s injury that resulted in the Plan’s advance for claims related to such injury.

By accepting an advance in claim payments, every Covered Person agrees to keep the Plan Administrator and Claims Supervisor informed of all material developments with respect to all such claims, actions or proceedings.

All Recovered Proceeds Are to Be Applied to Reimbursement of the Plan
The Covered Person agrees to automatically assign his/her rights against any Third Party or insurer when this provision applies. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person’s Third Party Claims.

By accepting an advance payment of claims for an injury, every Covered Person agrees to reimburse Plan for all such advances by applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of the medical expenses for which any advance has been made by the Health Plan. In such event the Plan must be fully reimbursed within 31 days, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney’s fees.

If the Covered Person fails to take action against a responsible Third Party to recover damages within one (1) year or within thirty (30) days of a request by the Plan, the Plan shall be deemed to have acquired, by assignment or Subrogation, a portion of the Covered Person’s claim equal to its prior payments. The Plan may thereafter commence proceedings directly against any responsible Third Party. The Plan shall not be deemed to waive its rights to commence action against a Third Party if it fails to act after the expiration of one (1) year, nor shall the Plan’s failure to act be deemed a waiver or discharge of the Lien described in this section.

The Plan reserves the right to be reimbursed for its court costs and attorneys’ fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

Also, The Plan’s right to Subrogation and reimbursement still applies if the Recovery received by the Covered Person is less than the claimed damage, and as a result, the claimant is not made whole.

If any Covered Person fails to reimburse the Plan as required by this section, the Plan may deny payment of claims and treat prior paid claims (related to the accident/injury) as overpayments recoverable by offset against
any and all future claims for benefits that may become payable on behalf of all Covered Persons within the injured Covered Person’s immediate family to the amount not reimbursed.

Once the claim is settled, the Plan will not pay future benefits for claims related to that Injury or accident unless it is determined by the Plan Administrator or Claims Supervisor that the original settlement was reasonable and the subsequent claims were not recognized in the settlement.

The Plan shall have no obligation whatsoever to pay medical or dental benefits incurred by a Covered Person if a Covered Person refuses to cooperate with the Plan’s Reimbursement and/or Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Reimbursement and Subrogation rights.

No Fault Insurance Coverage
If the Covered Person is required to have No-Fault insurance coverage, the automobile No-Fault Insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of:

- the maximum amount of basic reparation benefit required by applicable law;
- the maximum amount of the applicable No-Fault Insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which the Covered Person is enrolled. Before related claims will be paid through this Plan, the Covered Person or his/her dependent will be required to sign a Reimbursement Agreement.

If the Covered Person or his/her dependent fails to secure No-Fault Insurance as required by state law, the Covered Person or dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself/herself and/or his/her dependents arising out of the accident.

Refund of Overpayment of Benefits - Right of Recovery
If the Plan pays benefits for expenses for the Covered Person or their Eligible Dependent, they or any other person or organization that was paid must make a refund to the Plan if:

1. all or some of the expenses were not paid, or did not legally have to be paid by the Covered Person or their Eligible Dependents.
2. all or some of the payment made by the Plan exceeds the benefits under the Plan.
3. all or some of the expenses were recovered from or paid by a source other than this Plan including another Plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If the Covered Person or any person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

RIGHT OF RECOVERY

Recovery from another plan under which the Covered Person is covered. This right of Subrogation and reimbursement also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner’s plan, renter’s plan, medical malpractice plan or any liability or insurance plan.

If the Covered Person’s total Recovery from all sources does not adequately reimburse him for his expenses and injuries, the Plan Administrator, in its sole and absolute discretion, may accept a lesser amount in full satisfaction of its rights. The Plan Administrator shall have sole authority to determine whether a Covered Person has been adequately reimbursed and whether to accept a lesser amount.
**Waiver of Subrogation Rights.** The Plan Administrator, in its sole and absolute discretion, may agree to waive the Plan's Subrogation rights. Such waiver shall not automatically occur in any matter. Waivers of the Subrogation and reimbursement interest of the Plan may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. Waivers of Subrogation and reimbursement interests will generally not be granted if the past medical expenses are greater than $500 or if the total judgment or settlement exceeds $5,000.

**Conflict Within the Plan.** If any portion of this Section on Subrogation and reimbursement is deemed to conflict with any other provision of the Plan on coordination of benefits of primary-secondary insurance coverage, the other portion of the Plan shall control and the provisions of this section shall supplement such other provisions to the extent that they are not inconsistent.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on any and all approved settlements.

**Conditions Precedent to Coverage.** The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined terms:**

"Covered Person“ means anyone covered under the Plan, including minor dependents.

"Lien" is a right created by law to obtain Reimbursement from monies paid by a Third Party in compensation for a loss. This means the Plan retains the right to repayment for the value of all benefits provided by the Plan that are associated with the Injury or Illness for which the Third Party is or may be responsible, plus the costs to perfect the Lien. To prevent a double Recovery on the payment of medical expenses, a Lien is created in favor of this Plan in providing payment of medical expenses for the injured Covered Person.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Reimbursement" means that the Plan has a right to be paid a Recovery received by the participant or to the extent not contrary to law, to offset all or any part of the Plan's Recovery against any amount the Plan or the Employer owes to the Covered Person or owes as benefits for the Covered Person.

"Subrogation" means the right of the Health Plan to be substituted in place of any Covered Person with respect to that Covered Person's lawful claim, demand, or right of action against a third party who may have wrongfully caused the Covered Person's injury or illness that resulted in a payment of benefits by the Plan.

"Third Party" means any Third Party including another person or a business entity.
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Missouri State University Group Medical Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Covered Persons who become Qualified Beneficiaries under COBRA. (Refer to General Plan Information section for contact information.)

Individuals may have other options available when losing group health coverage. For example, instead of enrolling in COBRA continuation coverage, an individual plan may be available through the Health Insurance Marketplace in their “special enrollment” period. By enrolling in coverage through the Marketplace, individuals may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, an individual losing eligibility under this Plan may qualify for a 30-day special enrollment period for another group health plan for which he/she is eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. More information is available about many of these options at www.healthcare.gov.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse or Sponsored Dependent of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

3. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the University, as is the Spouse, Sponsored Dependent, surviving Spouse, Sponsored Dependent or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse, Sponsored Dependent or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.
An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse, Sponsored Dependent or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Covered Person would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A covered Employee's enrollment in any part of the Medicare program.
5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
6. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse, Sponsored Dependent or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the University, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, Sponsored Dependent, or Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse or Sponsored Dependent's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will
also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and end 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the employee,
3. commencement of a proceeding in bankruptcy with respect to the employer, or
4. **enrollment** of the employee into any part of Medicare.

**IMPORTANT:**

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse, Sponsored Dependent or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.
NOTICE PROCEEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the Plan Administrator.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives **timely notice** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, Sponsored Dependents, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse, Sponsored Dependent or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
   (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
   (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

3. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, Sponsored Dependent, surviving Spouse or Sponsored Dependent, or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

4. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

5. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60
days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

**IF YOU HAVE QUESTIONS**
If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Missouri State University Group Medical Plan is the benefit plan of Missouri State University, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Missouri State University to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Missouri State University shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Covered Person's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Supervisor to pay claims.
7. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
8. To maintain the Plan in accordance with all applicable State and Federal laws. If this Plan has not been amended according to a required change, the administration of the Plan will comply with the change until such time that the Plan is amended.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS SUPERVISOR IS NOT A FIDUCIARY. A Claims Supervisor is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator. The Claims Supervisor shall have the authority and responsibility to administer the Plan’s claims procedures, to process claims for benefits in accordance with Plan provisions, and to file claims with the insurance companies, if any, who issue stop loss insurance policies to the Plan. All funds for the payment of claims will be provided by the Plan Administrator.

DELAY OF DUTIES OF PLAN ADMINISTRATOR OR CLAIMS SUPERVISOR DUE TO FORCE MAJEURE. Force Majeure is a circumstance not within a person’s control, including but not limited to: fire, flood, war, civil disturbance/riot, court order, strike, partial or complete destruction of facilities, etc. No suit or action in law or equity may be taken against them on account of any of these events. The Plan Administrator and Claims Supervisor will have no liability or obligation if their respective services are delayed or not provided or if medical care is delayed, not provided, or covered as non-network care due to Force Majeure. The Plan Administrator and Claims Supervisor will, however, make a good-faith effort to provide services during and subsequent to any of these events.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

1. General. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected
Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Missouri State University's workforce are designated as authorized to receive Protected Health Information from Missouri State University Group Medical Plan ("the Plan") in order to perform their duties with respect to the Plan: Director of Human Resources and Assistant Director of Human Resources, Benefits, and members of the University's Office of Human Resources who have Plan-related responsibilities.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Active Employee Coverage: Funding is derived solely from the funds of the Employer.

For Retired Employee Coverage: Funding is derived solely from contributions made by University Retired Employees.
For Dependent Coverage: Funding is derived solely from the funds of the Active Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Supervisor.

Assignment and Non-Alienation of Benefits: Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no benefit, right or interest of any member hereunder shall at any time be used or be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach—charge or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

Assignment means, for purposes of this Plan, that the Plan may pay any benefits due under this Plan directly to the Provider. The rights of a participant and the benefits to which he is entitled or for which he applies under the Plan are not assignable, except for assignment of payments directly to a provider, or in accordance with the subrogation provisions of the Plan. The Plan has full discretionary authority to accept or reject an assignment. The provisions of this Plan shall supersede any and all other assignment or alienation provisions, under whatever terms that may be used, that a member may make with a provider of health care services. Moreover, this Plan has priority lien against any and all proceeds that may be due the plan.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

1. A copy of the Trust agreement.
2. A complete list of employers and employee organizations sponsoring the Plan.

Service of legal process may be made upon a Plan trustee.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

The Plan Administrator will have final determination of benefits if there are typographical or grammatical errors that appear in this document. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

PHYSICAL EXAM

The Plan has the right and opportunity to examine any Covered Person with respect to a claim for benefits that is pending under the Plan when and as often as it may reasonably require and at the Plan's expense. A Covered Person is required by the Plan to submit to such examination as a condition of coverage. This may be required to assist the Plan Administrator/Claims Supervisor in determination of non-covered services (i.e., malpractice claim, suspected felony, or other non-covered service).

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the University shall find that an attempt has been made with respect to any payment due or to become due to any
Participant, the University at its sole discretion may terminate the interest of such Participant or former Participant, his spouse, Sponsored Dependent, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such Participant of former Participant, as the University may determine, and any such application shall be complete discharge of all liability with respect to such benefit payment.

AMENDING (MATERIAL MODIFICATIONS) AND TERMINATING THE PLAN

The Employer will notify Employees of material reductions in covered services or benefits (for example, reductions in benefits or increases in deductibles and copayments) generally within 60 days of adoption of the change, or as required by law.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any). Material Modifications to the Plan will be provided to all Covered Persons in the time period required by law.

LEGAL PROCEEDINGS

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirement of the Plan, nor shall such action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Plan.

TIME LIMITATION

If any time limitation of the Plan with respect to giving notice of claims or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Plan is existent, such limitation is hereby extended to agree with the maximum period permitted by such law.

WORKERS’ COMPENSATION NOT AFFECTED

This Plan is not in lieu of and does not affect any requirement for coverage by Workers’ Compensation insurance.

STATEMENTS

In the absence of fraud, all settlements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representations is or has been furnished to such Covered Person.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining applicability and implementing the terms of this provision of this Plan or any provision of similar purpose of any other plans, the University may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information with respect to any person, which the University deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the University such information as may be necessary to implement this provision.

MISCELLANEOUS

Section titles are for the convenience of reference only, and are not to be considered in interpreting this Plan. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

COOPERATION BY COVERED PERSON

Circumstances may arise in which the Employer or the Claims Supervisor may require a Covered Person to furnish information concerning an Injury or Sickness, or a service or supply relating to that Injury or Sickness, or any other information that directly or indirectly relates to benefits paid or payable from the Plan. Each Covered Person, in consideration of the coverage provided by the Plan, must fully cooperate and provide any and all information requested and execute any and all documents that will enable the Employer or the Claims Supervisor to access such information. In the event a Covered Person fails to comply with this cooperation provision within 30 days of a request or provides false information in response to such request, payment of all benefits under the Plan (whether or not such benefits relate to the requested information) may be suspended and/or coverage may be terminated either retroactively or prospectively in the Employer’s sole discretion. In addition, the Employer or the Claims Supervisor may pursue any other remedy available to it, including obtaining an injunction to require cooperation, or recovering from the covered person or beneficiary damages for any loss incurred by it as a result of the failure to cooperate or the provision of false information.
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Supervisor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Employer may insure claims for specific and/or aggregate "Stop-Loss" claim reimbursement through a re-insurance contract.

PLAN NAME: Missouri State University Group Medical Plan

PLAN NUMBER: 501

GROUP NUMBER: 090188SMSU

TAX ID NUMBER: 44-6000308

PLAN EFFECTIVE DATE: September 1, 1988. As restated January 1, 2018 and herein revised January 1, 2016 to consolidate changes from Amendments 1-3.

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Missouri State University
901 South National Avenue
Springfield, Missouri 65897
(417) 836-5102

PLAN ADMINISTRATOR

Missouri State University
901 South National Avenue
Springfield, Missouri 65897

Contact the Office of Human Resources regarding plan administration, (417) 836-6616

CLAIMS SUPERVISOR

Med-Pay, Inc.
PO Box 10909
Springfield, Missouri 65808
(417) 886-6886 or (800) 777-9087

UTILIZATION REVIEW COORDINATOR

MPI Care
PO Box 10909
Springfield, Missouri 65808
(417) 886-6886 or (800) 777-9087
BY THIS AGREEMENT, Missouri State University Group Medical Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Missouri State University on or as of the day and year first below written.

By ____________________________

Plan Administrator
Missouri State University

Date ________________ January 1, 2018

Witness ____________________________

Date ________________ January 1, 2018
VIII.

RECOMMENDED ACTION - Resolution authorizing closed meeting

The following resolution was moved by ________________ and seconded by ________________:

BE IT RESOLVED by the Board of Governors for the Missouri State University that a closed meeting, with closed records and closed vote, be held during a recess of this Executive meeting of the Board of Governors to consider items pursuant to

A. R.S.Mo. 610.021(1). “Legal actions, causes of action, or litigation involving a public governmental body...”

B. R.S.Mo. 610.021(2). “Leasing, purchase or sale of real estate by a public governmental body...”

C. R.S.Mo. 610.021(3). “Hiring, firing, disciplining or promoting of particular employees by a public governmental body...”

D. R.S.Mo. 610.021(6). “Scholastic probation, expulsion, or graduation of identifiable individuals...”

E. R.S.Mo. 610.021(9). “Preparation, including any discussions or work product, on behalf of a public governmental body or its representatives for negotiations with employee groups;”

F. R.S. Mo. 610.021(11) and (12). “Specifications for competitive bidding...,” and “Sealed bids and related documents...;”

G. R.S.Mo. 610.021(13). “Individually identifiable personnel records, performance ratings or records pertaining to employees or applicants for employment...;”

H. R.S.Mo. 610.021(14). “Records which are protected from disclosure by law;” and

I. R.S.Mo. 610.021(17). “Confidential or privileged communications between a public governmental body and its auditor,...”

VOTE: ___ AYE

___ NAY