Missouri State™
UNIVERSITY

# GROUP 5Eb¢AL PLAN

Approved by Board of Governors
January 1, 201y

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## INTRODUCTION

This document is a description of Missouri State University Employee Dental Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain other expenses.

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 University 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.

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.

Dental care has become an increasingly common and expensive medical cost in recent years. Yet, dental health can be maintained easily through regular, routine care. Therefore, in addition to reimbursement for much of the cost of major procedures, the Plan encourages preventive and restorative dental care in order to avoid future, more costly major dental expenses.

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.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**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 rights under the Plan.

## 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.)

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

**TIMELY FILING OF CLAIMS:** Claims must be filed with the Claims Supervisor within 365 days of the date charges for the service were incurred. 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 File a Claim".)

**PARTICIPATING PROVIDER ORGANIZATION:** The Plan is a plan which contains multiple Participating Provider Organizations. When a Covered Person uses a Network Provider, any discounts applied to the services rendered will be written-off by the Network Provider. When a Covered Person uses Non-Network Provider, the Covered Person is responsible for any amounts over the Usual and Customary Allowance.

Refer to your ID card for specific information about the dental network, including name, phone number and web site.

### 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.

### DENTAL BENEFITS

**Calendar Year Deductible**

| | |
|---|---|
| Per Covered Person | $50 |
| Per Family Unit | $150 |

The deductible applies to these Classes of Service:

Type II/Class B Services – Basic
Type III/Class C Services – Major
Type IV/Class D Services – Temporomandibular Joint Dysfunction (TMJ)

**Dental Percentage Payable**

| | |
|---|---|
| Type I/Class A Services- Preventive | 80% |
| Type II/Class B Services- Basic | 80% |
| Type III/Class C Services- Major | 50% |
| Type IV/Class D Services- Temporomandibular Joint Dysfunction (TMJ) | 50% |

**Maximum Benefit Amount**

| | |
|---|---|
| Per Covered Person per Calendar Year | $1,000 |

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan benefits or requirements.

## ELIGIBILITY

**Eligible Classes of Participants.** All full-time Active Employees on regular appointment is the class of Participants eligible for coverage under the Plan.

**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.

**(c)** 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

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.

**Eligible Classes of Dependents.** The Plan Administrator may from time to time require documentation to substantiate eligibility. A Dependent is any one of the following persons:

**(1)** Spouse of a covered Active Employee

The term "Spouse" shall mean the person recognized as the covered Active 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. Proof of marriage is established by one of the following:

**(a)** a copy or abstract of the public record of marriage, or a copy of the church record of marriage, containing sufficient data to identify the parties, the date and place of marriage;

**(b)** an affidavit of the clergyman or magistrate who officiated; or

**(c)** an original certificate of marriage, if the Plan Administrator is satisfied it is genuine and free from alteration.

**(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) have a single dedicated relationship with the Employee of at least 12 months duration; (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

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.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom a person 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. 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;

**(b)** 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;

**(c)** 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;

**(d)** 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.

**(4)** Totally Disabled Child of a Covered Active Employee

A covered Dependent Child who reached 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 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 home, but who are not eligible as defined and the Legally Separated or divorced former Spouse or former Sponsored Dependent of the Employee (Refer to Continuation of Coverage Rights under COBRA section.)

**Dependents who are also Employees of the University**

If a Full-Time Employee is also eligible as a Dependent (Spouse or Child), the 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. He 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..

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. However, the Employee declining individual coverage and enrolling as a Dependent will not receive any applicable premium credit.

When both parents are Employees (regardless of marital status to each other), the Dependent Children may only be enrolled under one covered parent, not under both.

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.

**ENROLLEE/ENROLLMENT PROVISIONS OF THE PLAN**

**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 Employee Dental 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 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.** An Employee must complete the necessary online enrollment forms for the newborn to be enrolled in the University's Employee Dental Insurance Plan. If coverage is not elected when first eligible, the newborn will be considered a Late Enrollee.

Charges for services are 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 30 days after the person becomes eligible for the coverage.

If two Employees (husband and wife) 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.

The annual **open enrollment** period 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/her dependents (including their 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 30 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 30 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

**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. (See Election to Decline Coverage section.)

**(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 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, 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 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed online enrollment is completed, 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).

**(i)** 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).

**(ii)** 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.

**(iii)** 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).

**(iv)** 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 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 Dependent(s) may be enrolled under this Plan as a covered Dependent of the covered Employee; 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 Spouse or Sponsored Dependent and new Dependents (i.e., step-children) 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 30 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. The enrollment form must be received by 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, the first day of the first month beginning after the date of the completed request for enrollment is received (i.e., marriage occurred on January 10. If the online enrollment is completed between January 10th and 31st, the effective date will be February 1. If the online enrollment is completed between February 1st and 9th, the effective date is March 1.);

**(b)** in the case of a Dependent's birth, as of the date of birth;

**(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; or

**(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 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 and satisfaction of the Eligibility Requirement, Active Employee Requirement and Enrollment Requirements of the Plan:

**Faculty and Non-Faculty:** 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.

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."

**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 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; and 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 Employee Coverage Terminates**. Employee coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Employee 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 COBRA Continuation Options):

**(1)** The date the Plan is terminated.

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

**(3)** The date of death of the covered Employee. (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 Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)

**(5)** The last day of the stability period in which the covered Employee 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.)

**(6)** The last day of the calendar month in which the Employee 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.)

**(5)** The last day the University and/or the Employee made any required contribution for the coverage if the full premium for the next period is not paid when due for COBRA coverage. If an Employee 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.

**(6)** If an Employee 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 Employee and covered 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 misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

**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, other 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.

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 at midnight 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 COBRA Continuation Options):

**(1)** The date the Plan or Dependent coverage under the Plan is terminated.

**(2)** The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

**(3)** The last day of the month in which a covered Spouse or Sponsored Dependent loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

**(4)** The last day of the month in which 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 the Employee 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 last day the University and/or Employee made the required contribution for coverage if the full premium for the next period is not paid when due for COBRA 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 Dependent 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, 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.**

## DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

### DEDUCTIBLE

**Deductible Amount.** This is an amount of dental 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.

**Family Unit Limit.** When the dollar 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.

### BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

### MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

### DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge considered incurred as follows:

**(1)** For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made.

**(2)** For a crown, bridge or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared.

**(3)** For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened.

**(4)** All other expenses are considered incurred at the time a service is rendered or a supply furnished.

However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Supervisor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

### PENALTY FOR LATE ENROLLEES AND PRIOR MISSING TEETH

For the first 24 months of continuous coverage, the following will be payable at 50% of the benefit otherwise payable, except if the Covered Expense is required solely for treatment of an Injury suffered while covered under the Plan:

**(1)** Type III Dental Expenses for a Late Enrollee; and

**(2)** The first replacement of teeth that are missing at the time the Covered Person becomes effective.

## COVERED DENTAL SERVICES

### Type I/Class A Services:
### Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

**(1)** **Routine oral exams.** This includes the examination and cleaning of teeth. Limit of two per Covered Person each Calendar Year.

**(2)** One **fluoride** treatment for covered Dependent children under the age of 19 each Calendar Year.

**(3)** **Space maintainers** limited to non-orthodontic treatment. Initial appliance only will be covered. Allowance includes adjustments in the first six (6) months after installation. Includes (a) fixed, unilateral, band or stainless steel crown type and (b) fixed, unilateral cast type.

**(4)** **Sealants** on the occlusal surface of a permanent posterior tooth for Dependent children under the age of 16, once per tooth in any thirty-six (36) consecutive month period.

**(5)** One **full mouth x-ray** (including panoramic x-rays or series of bitewings) in any thirty-six (36) consecutive month period.

**(6)** One **bitewing x-ray** series (up to four bitewings) two times per Calendar Year.

### Type II/Class B Services:
### Basic Dental Procedures

**(1)** **Emergency palliative treatment for pain.** This service is not billable when any service other than x-rays are performed.

**(2)** **Non-Routine, unscheduled visits** (problem-focused exams).

**(3)** **Diagnostic consultation** with a dentist other than the one providing treatment limited to one consultation for each dental specialty per Covered Person per Calendar Year.

**(4)** Other intraoral x-rays (i.e., **Periapical or occlusal x-rays**) not included in Type I/Class A services.

**(5)** **Fillings**, other than gold. When multiple fillings are performed on the same tooth and on the same date of service, they are combined to the most comprehensive procedure. This benefit includes a stainless steel crown for use on primary teeth of children.

**(6)** **Sedative Fillings**. This temporary restoration service which is intended to relieve pain is limited to two fillings per tooth prior to a permanent filling or other restoration.

**(7)** **Endodontics** (root canals). Multi-visit procedures are payable after the final visit in which the procedure is completed (i.e., crowns, dentures, bridges, root canals). Includes routine x-rays and cultures but excludes final restoration (See separate benefit.) Note: Apicoectomy and retrograde filling are covered as a separate procedure only if performed more than one (1) year after the root canal therapy is completed.

**(8)** **Periodontics** (surgical and non-surgical gum treatments). Surgical treatment of diseases of the gums and bone supporting the teeth includes muco-gingival surgery, osseous surgery, osseous graft, pedicle soft tissue graft, free soft tissue graft, gingivectomy and gingivoplasty. Allowance include the treatment plan, local anesthetics and post-surgical care. All periodontal maintenance procedures performed within three months after completion of periodontal surgery will be considered part of the surgical service and are not a separate covered expense. This includes re-evaluation.

Note: (a) Only one periodontic surgical procedure is covered for each quadrant in a Calendar Year. (b) Occlusal adjustment not involving restorations and done in conjunction with periodontic surgery is limited to a maximum of four (4) quadrants in a Calendar Year. (c) Scaling and root planning (full mouth) limited to once each quadrant two times per Calendar

Year. (d) Periodontal appliance limited to one (1) appliance each three (3) year period. (e) Periodontal prophylaxis.

**(9)** **Extractions**. This service includes local anesthesia and routine post-operative care related to the removal of teeth (uncomplicated, erupted or impacted.)

**(10)** **Oral surgeries** not listed in Class B Services or listed as excluded by this Plan. Follow-up procedures performed due to complications of a surgical procedure are not payable as a separate benefit. Periodontal procedures to implant antibiotic-impregnated materials are not covered. Includes routine x-rays, the treatment plan and post-surgical care.

**(11)** **General anesthetics** are only payable as a separate procedure when required for complex oral surgical procedures covered under this Plan and only when not performed in a Hospital setting.

**(12)** **Antibiotic drugs** administered by the Physician.

**(13)** **Repairing** bridges; repair and relining dentures (only if greater than one (1) year from initial installation and then not more than once each two (2) Calendar Year period thereafter); adding a tooth to a partial denture; recementing bridges, crowns, inlays or space maintainer.

**(14)** Diagnostic **laboratory** tests

**(15)** Oral **Pathology** services.

**(16)** **Other Services** not listed above. Such as the following: (a) Biopsy of oral tissue; (b) Pulp vitality test; and (c) Diagnostic cast limited to one (1) time every twenty-four (24) consecutive month period.

**Type III/Class C Services:**
**Major Dental Procedures**

**(1)** **Gold restorations**, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold. Replacements allowed only after five (5) years have elapsed from last placement.

**(2)** **Inlays**.

**(3)** Installation of **crowns**. Crowns are covered only if the tooth cannot be restored by a filling or are associated with prosthodontics. Crowns for the primary purpose of periodontal splinting, altering vertical dimension or restoring occlusion are not covered. Types of crowns include: (a) Plastic (Acrylic); (b) Plastic, prefabricated; (c) Plastic with non-precious or semi-precious; (d) metal: (e) Porcelain; (f) Porcelain with non-precious or semi-precious; (g) metal or gold; (h) Gold 3/4 for full cast; and (i) Non-precious or semi-precious metal full cast. Steel post and composite or amalgam core, in addition to crown, is covered only for teeth that have had root canal therapy.

**(4)** Installing partial, full or removable **dentures** or **fixed bridgework** to replace one or more natural teeth which were extracted while the person was covered for this benefit. This service also includes all adjustments made during six following the installation. Also includes installing precision attachments for removable dentures.

Initial placement of fixed bridges or removable dentures to replace teeth which *were missing prior to* the effective date of the Covered Person's coverage are covered as follows:

(a) If services are within the first twenty-four (24) months of coverage: benefits are payable at 50% of the benefit payable for Type III Dental Expenses.
(b) If services are after the first twenty-four (24) months of coverage: benefits are payable at the level indicated for Type III Dental Expenses.

If the prosthodontic device also includes replacement of a natural tooth removed while covered under this Plan, the benefit will include the replacement of the missing tooth without reduction of the benefits.

**(5)** Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

**(a)** The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits;

**(b)** The existing denture or bridgework cannot be made serviceable and both of the following time periods is met:

**(i)** The prosthodontic device was installed at least five years prior to its replacement and cannot currently be made serviceable and

**(ii)** The Covered Person has been covered under this Plan for at least twelve (12) consecutive months;

**(c)** The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within twelve months from the date the temporary denture was installed.

**Type IV/Class D Services:**
**Treatment of Temporomandibular Joint Dysfunction**

Only the Dental Services listed below will be considered a Covered Expense under this benefit.

**(1)** **Office visit - Adjustment to appliance.** No more than six (6) consecutive months after sealing or placement of appliance.

**(2)** **Transcutaneous electro-neural stimulation.** No more than four (4) treatments in a six (6) month period.

**(3)** **Trigger point injection of local anesthetic into muscle fascia.** No more than four (4) treatments in a six (6) month period.

**(4)** **Mandibular orthopedic repositioning appliance.** Only one (1) appliance per person in a five (5) year period.

**EXTENSION OF DENTAL BENEFITS**

An expense incurred in connection with a Dental Service that is completed after a Covered Person's benefits cease will be deemed to be incurred while he is insured if:

**(1)** The first impressions for fixed bridgework and full or partial dentures were taken and/or abutment teeth fully prepared while the person is insured. The device must be installed or delivered to the individual within three (3) calendar months after the insurance terminates.

**(2)** The tooth must be prepared for a crown, inlay or onlay while the person is insured. The crown, inlay or onlay must be installed within three (3) calendar months after the insurance terminates.

**(3)** The pulp chamber of the tooth must be opened for root canal therapy while the person is insured. The treatment must be complete within three (3) calendar months after the insurance terminates.

There is **no** extension for any dental services that is not shown above and on the preceding pages.

## PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $200 or more, a predetermination of benefits form should be submitted.

**A pretreatment plan helps reduce your out-of-pocket dental costs.** Unlike medical care and treatment, many dental procedures are entirely elective and can be treated in several ways. It's important that you ask your Dentist, dental surgeon or Physician to help you or your dependents choose the most effective and economical course of treatment. By doing so, you can reduce your own out-of-pocket expenses for treatments that may not be covered by the Plan or are covered only to a limited extent.

Pre-determination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a Covered Person qualifies at the time services are completed.

A regular dental claim form is used for the predetermination of benefits. This form can be obtained from the human resources office or www.med-pay.com. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Supervisor at this address:

Med-Pay, Inc.
PO Box 10909
Springfield, Missouri 65808
(417) 886-6886 or (800) 777-9087

The Claims Supervisor will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

## ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

Even though Dental Implants are not covered by this Plan, 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. The underlying situation being treated must be a covered expense.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

## EXCLUSIONS

A charge for the following is not covered:

**(1)** **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

**(2)** **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan.

**(3)** **Broken appointments.** Charges for broken or missed dental appointments.

**(4)** **Bruxism.** Services, procedures or appliances that treat/prevent bruxism (teeth grinding or clenching).

**(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.** Services, procedures or appliances that are cosmetic in nature, i.e., veneer facings or similar properties of crowns or pontics placed on or replacing teeth in back of the second bicuspid; teeth whitening processes and characterizing and personalizing prosthetic devices.

**(7)** **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

**(8)** **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

**(9)** **Experimental.** Expenses for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

**(10)** **Felonious behavior** (as defined by 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, eye-witness 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.

**(11)** **Government.** 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.

**(12)** **Hospital charges.** Services and supplies received from a Hospital.

**(13)** **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

**(14)** **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

**(15)** **Instructional charges.** Instruction for plaque control, oral hygiene and diet.

**(16)** **Medical services.** Services that are deemed to be medical services.

**(17)** **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

**(18)** **No listing.** Services which are not included in the list of covered dental services.

**(19)** **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay including any charges that are discounted or rebated.

**(20)** **Non-prescription drugs.** Charges for non-prescription drugs.

**(21)** **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary or that does not meet common dental standards.

**(22)** **Occupational.** Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.

**(23)** **Orthodontia.** Expenses for orthodontic services or supplies and orthodontics to correct malocclusion which may have caused Temporomandibular Joint Dysfunction symptoms.

**(24)** **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw. (Refer to the Medical Benefits of this Plan.)

**(25)** **Personalization.** Personalization of dentures.

**(26)** **Plan design.** Charges excluded or limited by the Plan design as stated in this document.

**(27)** **Public Programs.** Expenses that a Covered Person or Dependent is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

**(28)** **Relative.** 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.

**(29)** **Replacement.** Replacement of lost or stolen prosthetic appliance. Replacement of a prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five years of the date of the last placement of these items unless:

(a) Only if the item cannot be made usable according to common dental standards;
(b) The replacement is required because of an accidental bodily Injury sustained while the person is covered under this section and the prosthetic appliance was in the mouth of the Covered Person and has been damaged beyond repair; or
(c) The replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth.

**(30)** **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.

**(31)** **Surgical implants.** Expenses for surgical implant of any type including any prosthetic device attached to it.

**(32)** **Unlawful charges.** To the extent that payment is unlawful where the Covered Person resides when the expenses are incurred.

**(33)** **Unnecessary care.** Expenses for unnecessary care, treatment or surgery.

**(34)** **Usual andCustomary Allowance.** Charges will be allowed at the Usual and Customary Allowance, contracted rate or billed amount, whichever is less unless specifically stated otherwise in the contract with that provider

**(35)** **War.** Any loss that is due to a declared or undeclared act or war.

**(36)** **Workers' Compensation.** Expenses for or in connection with an injury or a sickness which is covered under any Workers' Compensation or similar law.

## DEFINED TERMS

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.

**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.

**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.

**Calendar Year** means January 1st through December 31st of the same year.

**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.

**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.

**Covered Expenses** means any medically necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in the Plan.

**Covered Person** is an Employee, Retiree (under COBRA) or Dependent who is covered under this Plan.

**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** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**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.

**Employee** means a person who is an Active, regular Employee of the University, regularly scheduled to work for the University in an employee/employer relationship.

**Employer** is Missouri State University.

**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 dental 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

**(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 Active Employee and the family members who are covered as Dependents under the Plan.

**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.

**Illness** means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous condition of a Covered Person. A recurrent illness will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Institution of Learning** means any accredited high school, accredited college or university, including other recognized educational institutions such as nursing schools, trade school, etc., with full-time curricula, regardless of the length of the term.

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

**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.

**Life Threatening** is defined as any serious illness or injury that:

- **(1)** May result in permanent impairment of a bodily function or permanent damage to a body part.
- **(2)** May necessitate immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.
- **(3)** Examples: burns, loss of organs, loss of limbs, and blindness.

**Medically or Dentally Necessary** care and treatment is recommended or approved by a Dentist; is consistent with the patient's condition or accepted standards of good dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of dental 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.

**Named Fiduciary** means Missouri State University which has the authority to control and manage the operation and administration of the Plan.

**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.

**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.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Other Facility Provider** shall mean any of the following: Ambulatory 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:

| | |
|---|---|
| Audiologist | Licensed Practical Nurse |
| Anesthetist | Pharmacist |
| Certified Athletic Trainer | Physical Therapist |
| Chiropractor | Physiotherapist |
| Licensed Clinical Social Worker | Psychologist |
| Emergency Medical Technician | Registered Nurse |
| Independent Laboratory Technician | Respiratory Therapist |
| Midwife | Speech – Language Pathologist |
| Occupational Therapist | Vocational Nurse |
| 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** 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 Ambulatory Surgical Center, or the patient's home.

**Participant** means an Active Employee.

**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.), Doctor of Dental Surgery (D.D.S.) and Doctor of Podiatry (D.P.M.).

**Plan** means Missouri State University Employee Dental 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.

**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. Fertility drugs and over-the-counter drugs/supplies are not a covered expense under the Plan unless stated otherwise.

**Preventive 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 Dental Benefits are payable as described in the Schedule of Benefits.

**Retired Employee** is a former Active Employee of the University who was retired while employed by the University, is eligible for and receiving a retirement pension from the University's public retirement plan, and who maintains continuous coverage under the University's Group Health Insurance Plan, and who elects to contribute to the Plan the contribution required from the Retired Employee.

**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.

**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.

**Sponsored Dependent** is defined on the Employer's Sponsored Dependent Missouri State University Affidavit form.

**Spouse** means the person recognized as the Participant's husband or wife under the laws of the state where the Participant lives. The Plan Administrator may require documentation proving a legal marital relationship. (Refer to the Eligibility section of this document.)

**Surviving Spouse or Sponsored Dependent** means the person recognized as the deceased covered Retired Employee's a) husband or wife (or the husband or wife of a deceased Active Employee who was eligible for retirement at the time of his/her death) under the laws of the state in which the Retired Employee lived or b) Sponsored Dependent; and who had been continuously covered since retirement as an eligible dependent of the Retired Employee prior to the death. This person is eligible only through COBRA coverage.

**Total Disability (Totally Disabled)** means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the University.

In the case of a Dependent child, 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.

**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)** The Plan Administrator or its designee has the discretionary authority to determine 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.

**Benefits are provided in accordance with the terms and conditions of this Plan,as set forth in this Summary Plan Description.**

Charges for 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 do I file a claim?**

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 an out of 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.

**(1)** Obtain a Claim form from the Claims Supervisor or www.med-pay.com.

**(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 Dentist 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 codes)
- Type of services rendered, with diagnosis and/or procedure 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 has not been previously submitted but relate to charges for services or treatments for which a Claim has been file are still are considered a new claim and must be filed in the time limit above.

**(2)** Corrected information submitted on an initial claim determination is considered an appeal and not a newly filed claim. The filing limit will follow the appeal guidelines explained further in this section.

**(3)** If the person is not capable of submitting the claim due to Illness, including mental or physician incapacity that made it unreasonably difficult to file the claim within the specified timeframe. 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)** 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.

## NOTICE OF DETERMINATIONS AND APPEALS

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 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 time frames 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 time frames 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 your provide the information or the end of the information gathering period, whichever is earlier.
The notice 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 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)** 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.

**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.)

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, you 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 will allow 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 cause 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 chart below. 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.

## C**laims 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**

| Type of Claim | Initial Claims | | |
|---|---|---|---|
| | **Claimant must be notified of determination as soon as possible but no later than…** | **Extension period allowed for circumstances beyond Claims Supervisor's control…** | **If additional information is needed, claimant must provide information within…** |
| **Pre-Service** | 15 days after Claims Supervisor's receipt of Claim (Including approval of Benefits) | One extension of 15 days. | 45 days of date of extension notice |
| **Pre-Service involving Urgent Care** | 72 hours after Claims Supervisor's receipt of Claim (including approvals) | Must provide notice within 24 hours of receiving Claim if additional information is needed | 48 hours. Claims Supervisor must notify claimant of determination within 48 hours of receipt of claimant's information. |
| **Concurrent: To end or reduce treatment prematurely** | 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 | N/a | N/A |
| **Concurrent: To deny your request to extend treatment** | Treat as any other pre or post service claim. | One extension of 15 days | 45 days after date of extension notice |
| **Concurrent involving Urgent Care** | 24 hours, if claimant's request is made at least 24 hours before the date treatment is scheduled to end. Otherwise, request is treated as "Pre-Service Urgent Care" claim (including approvals of benefits) | None | N/A |
| **Post-Service** | 30 days after Claims Supervisor's receipt of Claim | One extension of 15 days | 45 days after date of extension notice |

| Type of Claim | 1st Level Appeal | | 2nd Level Appeal | |
|---|---|---|---|---|
| | **Claimant must file appeal within…** | **Claimant will be notified of determination as soon as possible but no later than…** | **Claimant must file appeal within…** | **Claimant will be notified of determination as soon as possible but no later than…** |
| **Pre-Service** | 180 days upon receipt of Claims Supervisor's notice of determination | 15 days after Claim Supervisor's receipt of appeal | 90 days following Claimant's receipt of determination notice | 15 days after Plan Administrator's receipt of appeal |
| **Pre-Service involving Urgent Care** | 180 days upon receipt of Claims Supervisor's notice of determination | 72 hours after Claims Supervisor's receipt of appeal | Not available | Not available |
| **Concurrent: To end or reduce treatment prematurely** | 180 days upon receipt of Claims Supervisor's notice of determination | 15 days after Claim Supervisor's receipt of the appeal | 90 days following Claimant's receipt of determination notice | 15 days after Plan Administrator's receipt of appeal |
| **Concurrent: To deny your request to extend treatment** | 180 days upon receipt of Claims Supervisor's notice of determination | Treat as any other pre or post service claim | 90 days following Claimant's receipt of determination notice | Treat as any other pre or post service claim |
| **Concurrent involving Urgent Care** | 180 days upon receipt of Claims Supervisor's notice of determination | 72 hours after Claims Supervisor's receipt of appeal | Not available | Not available |
| **Post-Service** | 180 days upon receipt of Claims Supervisor's notice of determination | 30 days of Claims Supervisor's receipt of appeal | 90 days following Claimant's receipt of determination notice | 30 days after Claims Review Committee's receipt of appeal |

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits 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 dental 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 Medicare.

**(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/Dentally Necessary; **(2)** Ordered by an appropriate Physician; **(3)** Not excluded under the Plan; and **(4)** Meets the standards of care for the diagnosis.

**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").

**(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 plan which covers the person as a COBRA beneficiary.

**(d)** When a child is covered as a Dependent and the parents are 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 patient 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)** For parents who were never married to each other, 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 parent (if the non-custodial parent is an Employee of the University).

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.

**(f)** If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient 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.

**(3)** 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. This Plan will always follow the standard Medicare Secondary Payer rules as may be revised from time to time.

**(4)** If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

**(5)** 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 or Sponsored Dependent 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 benefit. 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 you are 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: or
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 you are provided health coverage. Before related claims will be paid through this Plan, the Covered Person or his dependent will be required to sign a Reimbursement Agreement.

If the Participant or his dependent fails to secure No-Fault Insurance as required by state law, the Participant or dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his dependents arising out of the accident.

**Refund of Overpayment of Benefits - Right of Recovery**
If the Plan pays benefits for expenses incurred on account of you or your Eligible Dependent, you 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 you or your 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 you 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.

## COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the 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 Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage 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 employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

**What is COBRA continuation coverage?** COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's 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 is:

**(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 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. If, however, an individual 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 not only common-law employees (whether part-time or full-time) but also 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., self-employed individuals, independent contractor, or corporate director).

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 is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

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 Plan participant 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 the Medicare program.

**(5)** A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., 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 occurs, 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 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?** An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the University's Plan. A

Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 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.

**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)** entitlement of the employee to 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 PROCEDURES:***

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 University or Plan Administrator, as applicable.

**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 University ceases to provide any group health plan (including successor plans) 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 becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

**(6)** 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 retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, Sponsored Dependent, surviving Spouse or Sponsored Dependent, or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

**(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 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.

**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.

**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 payment that is made to the Plan by the date that is 30 days after the first day of that 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 University and the entity that provides Plan benefits on the University's behalf, the University is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot 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 sent 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 Employee Dental Plan is the benefit plan of Missouri State University, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Missouri State University to be Plan Administrator and serve at the convenience of the University. If the Plan Administrator 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 Plan Participant'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.

Service of legal process may be made upon the Plan Administrator.

**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 Plan Participant'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 University.

**For Dependent Coverage:** Funding is derived solely from the contributions made by the covered Active Employee.

**For COBRA Continuants:** Funding is derived solely from the contributions made by the covered COBRA Continuant.

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

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, due to a clerical error, 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 Plan Participant, if it is requested, the amount of overpayment will 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 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.

## TYPE OF ADMINISTRATION

The Plan is a self-funded group dental Plan and the administration is provided through a Third Party Claims Supervisor. The funding for the benefits is derived from the funds of the University and contributions made by covered Employees.

**PLAN NAME:** Missouri State University Employee Dental Plan

**PLAN NUMBER:** 502

**GROUP NUMBER:** 090188MSU

**TAX ID NUMBER:** 44-6000308

**PLAN EFFECTIVE DATE:** September 1, 1988. Restated January 1, 2018.

**PLAN YEAR ENDS:** December 31st

## EMPLOYER INFORMATION

Missouri State University
901 South National
Springfield, Missouri 65804
(417) 836-5102

## PLAN ADMINISTRATOR

Missouri State University
901 South National
Springfield, Missouri 65804
(417) 836-6616

## CLAIMS SUPERVISOR

Med-Pay, Inc.
PO Box 10909
Springfield, Missouri 65808
(417) 886-6886 or (800) 777-9087