Dental Insurance Booklet

DENTAL BENEFITS
FOR
Missouri State University
SEPTEMBER 1, 1988

Revised June 2003

INTRODUCTION

The Missouri State University Employee Dental Plan is a contributory, self-funded dental plan. That is, the University, Employees, and COBRA Continuants provide the funds with which benefit payments are made. A third party administrator processes dental claims and payments for the University.

Missouri State University, hereinafter referred to in this document as the "University," hereby established the benefits, rights, and privileges which shall pertain to participating employees, COBRA continuants, and eligible dependents of participating employees and COBRA continuants, as defined herein, and who shall be referred to as "Covered Persons", and which benefits are provided as established by this Plan Document, hereinafter referred to as the "Plan."

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

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 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, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force (Refer to page 22 for circumstances under which dental benefits may be extended). An expense for a service or supply is incurred on the date the service or supply is furnished.

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.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees, COBRA continuants, and the eligible dependents of covered Employees and COBRA continuants and is organized into the following sections:

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

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Dental Benefits. Explains when the benefit applies and the type of charges covered.

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

Exclusions and Limitations. Shows what charges are not covered and/or the coverage limitations under this Plan.

Claim Provisions. Explains how to file a claim.

Coordination of Benefits. Shows how the Plan pays when a person is covered under more than one insurance plan.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options that are available.

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, FUNDING, AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Participants.

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

1. A full-time Active Employees (faculty and non-faculty) on regular appointment.
2. All full-time Active Employees (faculty and non-faculty) whose spouse is also a full-time Active Employee and whose said spouse is covering them as a dependent under the University's Group Dental Insurance Plan.

All Participants in the above eligible classes will have coverage effective on the date shown in the Effective Date Section, subject to enrollment procedures and payment of required contributions.

Eligibility Requirements for Participant Coverage. A person is automatically eligible for Participant coverage from the first day that he or she:

1. Is a full-time Active Employee of the University. An employee is considered to be full-time if he or she is on regular appointment (faculty and non-faculty) with the University for that work, or
2. Is in a class eligible for coverage.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

1. A covered Active Employee's spouse. The term "spouse" shall mean the person recognized as the covered Active Employee's husband or wife under the laws of the state where the covered Active Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.
2. An unmarried child or children of a Participant, from birth to the limiting age of 19 years. The term "children" shall include natural children, stepchildren, adopted children, or children placed with a covered Participant in anticipation of adoption.
3. A Dependent child may continue to be covered after age 19, however, provided the child
    a. unmarried
    b. primarily dependent upon the Participant for support and maintenance as defined by the Internal Revenue Service (IRS)
    c. under the limiting age of 25 years, and
    d. enrolled as a full-time student at an accredited, post-secondary school institution of learning, which has a full-time curricula, regardless of the length of the institution's term. Examples of a post-secondary school institution of learning include: college, university, business school, trade school, nursing school, community college, junior college, business college, mortuary school, cosmetology school, or other similar educational institutions.

    Full-time student status is determined by the institution of learning where the Dependent child is enrolled. If the Dependent child is concurrently enrolled at multiple institutions of learning, the hours enrolled at each institution may be combined to calculate full-time status. In instances where the Dependent child is concurrently enrolled at multiple institutions of learning, full-time status is considered to be enrollment in at least twelve(12) credit hours, if pursuing an undergraduate degree or enrollment in at least nine(9) credit hours is pursuing a graduate degree.

    If the Dependent child withdraws from the institution of learning or drops a course or courses such that he/she is taking less than the required number of courses or credit hours to be a full-time student, as determined by the institution of learning, the Dependent child's health insurance coverage will cease at that point according to the "When Dependent Coverage Terminates" section of this Plan.

    Plan benefits provided to a Dependent child who is at least 19 years, but not 25 years old, but who does meet all of the requirements outlined in (a) through (d) above will be recouped by the Plan in accordance with its rights for reimbursement.

When the child reaches either limiting age, coverage will end on the last day of the child's birthday month. A full-time student will be covered during the period between semesters (or terms) provided that he/she has demonstrated an intent to continue as a full-time student in the next semester (or term). Intent to continue as a full-time student can be demonstrated by such actions as pre-enrollment or pre-registration as a full-time student or through the payment of fees or a portion thereof, for the next semester (or term).

For the purpose of extending COBRA continuation coverage to a Dependent student who would otherwise lose his/her coverage, the 60-day period during which he/she (or the parents) must notify the University that he/she is no longer enrolled as a full-time student will begin either upon the start of classes in the next semester (or term), or at the point when the Dependent student (or the Parents) first becomes aware that he/she will not return to school in the next semester (or term), whichever occurs first.

A Dependent child must be in the custody of and financially dependent upon the Participant for support. The phrase "financially dependent upon" shall mean dependent upon the Participant for support as defined by the Internal Revenue Code. This requirement is waived if the Participant is required to provide coverage due to court order or divorce decree for a child or children not in his/her custody or not wholly dependent upon him/her. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights

The unmarried child or children from whom the covered Participant is the Legal Guardian. The unmarried child or children must be financially dependent upon the covered Participant for support. The limiting age provisions listed in paragraph (2) above also apply.

4. A covered Dependent child who is totally disabled, incapable of self-sustaining employment by reason of mental retardation or physical handicap, financially dependent upon the covered Participant for support, unmarried and covered under the Plan when reaching the limiting age of 19 years, or the otherwise limiting age of 25 years if a full-time student at an accredited college or university and financially dependent upon the covered participant at the time of the total disability. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.
5. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. 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:

1. Other individuals living in the covered Participant's home, but who are not eligible as defined; or
2. The legally separated or divorced former Spouse of the active Employee; or

3. Any person who is on active duty in any military service of any country.

If a person covered under this Plan changes status from Active Employee to Dependent or Dependent to Active 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.

If both husband and wife are Active Employees, their children will be covered as Dependents of the husband or wife, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Active Employee will become eligible for Dependent coverage on the first day that the Active Employee is eligible for coverage if the family member is in an eligible class of dependents and is properly enrolled.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

ENROLLMENT

Enrollment Requirements. An Active Employee is automatically enrolled in the University's dental care plan. The Active Employee must complete the necessary enrollment forms.

The Active Employee may elect to cover his/her dependents by completing the necessary enrollment form. Dependents who are not enrolled when first eligible for coverage may be subject to the penalty for late enrollees (see page 15, Penalty for Late Enrollees and Prior Missing Teeth).

A newborn child(ren) of an Active Employee will be covered from the moment of birth provided the child(ren) is properly enrolled as a Dependent of the Active Employee within thirty (30) days of the child's date of birth. If the newborn child is required to be enrolled and is not enrolled within thirty (30) days of birth, the enrollment will be considered a Late Enrollment.

Timely or Late Enrollment

(Note: Since Active Employees are automatically enrolled in the Plan, these provisions only apply to dependent spouses and children.)

1. **Timely Enrollment**- The enrollment will be timely if the completed form is received by the Plan Administrator not later than 30 days after the person first becomes eligible for the coverage.

    If two Active Employees (husband and wife) are covered under the Plan and the Active Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other Active 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". If late enrollment is allowed, Dependents will be subject to the late enrollee provisions of the Plan.

   The enrollment date for a Late Enrollee is the first date of coverage. Coverage begins the first of the month after the required premium has been collected.

EFFECTIVE DATE

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

Faculty: First of the month following employment.

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

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.

If an Active Employee is not Actively at Work on the date that coverage would otherwise become effective, his/her coverage shall become effective on the day he/she returns to active work. All Active Employee coverage under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective, provided such Active Employee is able to be Actively at Work at such time. If the Active Employee is not Actively at Work on the date the Active Employee coverage would otherwise take effect, but was able to do so at 12:01 A.M. Standard Time had such work been commenced at that time, such Active Employee shall be eligible for coverage on that date.

Effective date of Dependent Coverage. A Dependent must be properly enrolled and the appropriate premium must have been paid for the coverage to take effect. The effective date of the 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 30 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 within 30 days of the Dependent becoming eligible for coverage (e.g., marriage, birth, adoption, legal guardianship), coverage will become effective the date of eligibility or the first of the month following the date of eligibility.
4. if the Active Employee enrolls the Dependent after the 30 days from the date of the Dependent's eligibility date, the Dependent is considered a Late Enrollee. The coverage will take effect the first of the month after the required premium deduction has been collected.

FUNDING

Cost of the Plan. The amount of contributions, if any,

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.

The University pays the entire cost of Active Employee coverage under this Plan. Covered Active Employees who elect Dependent coverage pay the entire cost of coverage for their Dependents.

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 Covered Persons shall have no further obligation to make additional contributions to the Plan.

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.

TERMINATION OF COVERAGE

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

1. The date the Plan is terminated.
2. The date the covered Participant's Eligible Class is eliminated.
3. The last day of the calendar month in which the covered Participant ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Active Employee. (See the COBRA Continuation Option.)
4. The last day the University and/or the Participant made any required contribution for the coverage.

Continuation During Periods of Leave of Absence or Layoff. A person may remain eligible for a limited time if active, full-time work ceases due to leave of absence or layoff. 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. 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 the Active Employee is on a University's Board of Governors approved, unpaid leave of absence, the Active Employee may continue coverage for no more than one (1) year if the required contributions are made.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

Family and Medical Leave Act (FMLA) requires Employers of fifty (50) or more Employees within a 75-mile radius to provide up to twelve (12) weeks of unpaid, job-protected leave to "eligible" Employees for certain family and medical reasons. Please refer to your Employee Handbook for the Family and Medical Leave Provisions/Questionnaire or request a copy at the Human Resources Office.

During any leave taken under the Family and Medical Leave Act, the University will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Active Employee had been continuously employed during the entire leave period.

If Plan coverage terminates for a covered Dependent(s) during the FMLA leave, coverage will be reinstated for the covered Dependent(s) if the Active 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.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all Eligibility and Enrollment requirements.

Active Employees on Military Leave. Active Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 18 months of extended dental care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage upon return from service. These rights apply only to Active Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

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

1. The date the Plan or Dependent coverage under the Plan is terminated.
2. The date that the Active Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
3. The date a covered Dependent loses coverage due to loss of dependency status. (See the COBRA Continuation Option.)
4. On the last day of the calendar month that he or she ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)
5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

CALENDAR YEAR DEDUCTIBLE - TYPES II,III,IV

Individual $50
Family Accumulation $150

TYPE OF COVERAGE	BENEFITS
TYPE I	
Preventive Care Deductible Waived, Benefit Percentage	80%
TYPE II	
Basic Restorative Benefit Percentage after Deductible is paid	80%
TYPE III	
Major Restorative Benefit Percentage after Deductible is paid	50%
TYPE IV	
Temporomandibular Joint Dysfunction (TMJ) Benefit Percentage after Deductible is paid	50%

CALENDER YEAR MAXIMUM BENEFIT (Per Covered Person)
Types I,II,III, and IV
$1,000

SCHEDULE OF DENTAL BENEFITS

DENTAL BENEFITS

Dental Benefits apply when covered charges are incurred by a Covered Person for dental care while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible

shown in the Schedule of Benefits. The deductible shall apply to Type II, Type III, and Type IV dental procedures.

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 the Family Unit will be considered satisfied for that year.

PAYMENT PERCENTAGE

After the deductible has been satisfied, the Plan will generally pay 80% of the Covered Person's Type II Dental Expenses and 50% of the Type III and Type IV Dental Expenses for the remainder of the benefit period subject to the limitations listed in the Schedule of Benefits.

Type I Dental Expenses (routine oral exams) are payable at 80% of **Usual and Reasonable Charges** for the service provided. This includes Covered Charges for the diagnosis, x-rays, cleaning and scaling, and fluoride treatment for dependent children under age 16 and space maintainers for missing primary teeth of a child which are placed at the time of a routine oral exam of such child.

MAXIMUM BENEFIT

The maximum benefit payable for Type I, Type II, Type III and Type IV Dental Expenses is $1,000 for a Covered Person during a calendar year.

PRE-DETERMINATION OF BENEFITS

Benefits may be determined before the Covered Person begins treatment if the charges for the treatment will be more than $200. The dentist should provide a description of the proposed treatment and charges on a Dental Claim Form. The form should then be submitted to the Claims Supervisor. The Claims Supervisor will respond to the dentist in writing indicating how much will be considered as Covered Expenses and how much the Plan will pay. When more than one method of treatment is available, the Plan will pay for the least expensive method of treatment, regardless of which method is actually used.

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.

PENALTY FOR LATE ENROLLEES AND PRIOR MISSING TEETH

For the first twenty-four (24) months of continuous coverage, the following will be payable at fifty percent (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.

TYPE I DENTAL EXPENSES

Type I Preventive Dental Services include the following:

1. **Prophylaxis and Fluoride Treatments**
    a. Routine Exam and Prophylaxis (limited to two(2) exams per Calendar Year). Allowance includes examination and polishing.
    b. Topical application of fluoride (limited to Dependent Children under age 19 and to one(1) treatment per Calendar Year).
2. **Space Maintainers** limited to non-orthodontic treatment. Initial appliance only will be covered. Allowance includes adjustments in the first six (6) months after installation. The following are the types of space maintainers that are covered under this Plan:
    a. Fixed, unilateral, band or stainless steel crown type.
    b. Fixed, unilateral, cast type.
3. **Topical Application of Sealants** limited to one treatment per tooth every thirty-six(36) consecutive month period for Covered Persons under age 16.
4. **Diagnostic Services** (examinations and diagnosis):
    a. **X-Rays**
        i. Initial or periodic oral examination limited to two(2) exams per Calendar Year.
        ii. Emergency palliative treatment. If visit for this treatment is billed along with x-rays, both charges will be covered under Type I Benefits. If services other than x-rays are billed, the services will be covered under the appropriate benefit. The charge for this treatment will not be covered.
        iii. Non-routine, unscheduled visits. If visit is billed along with x-rays, both charges will be covered under Type I Benefits. If services other than x-rays are billed, the services will be covered under the appropriate benefit. The visit charge will not be covered.
    b. **Other Services**
        i. Biopsy of oral tissue.
        ii. Bacteriologic culture.
        iii. Histopathologic examination.
        iv. Pulp vitality test.
        v. Diagnostic cast limited to one(1) time every twenty-four(24) consecutive month period.

TYPE II DENTAL EXPENSES

Type II basic dental services include the following:

1. Office Visits and Examinations

a. 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.

2. **Restorative Services** (Multiple restorations on one (1) surface will be considered one (1) restoration.)
    a. Amalgam restorations.
    b. Synthetic restorations include silicate cement, acrylic or plastic and composite resin.
    c. Stainless steel crown.
    d. Pin retention exclusive of restorative material.
3. **Endodontic Services** (Includes routine x-rays and cultures, but excludes final restoration.)
    a. **(**Pulp capping, direct.
    b. Remineralization (Calcium Hydroxide) as a separate procedure.
    c. Vital pulpotomy.
    d. Apexification.
    e. Root canal therapy of non-vital (nerve dead) includes traditional therapy and medicated paste therapy (N2 Sagenti).
    f. Apicoectomy.
    g. Retrograde filling.
    h. Apical curettage.
    i. Hemisection.

        *(Apicoectomy and retrograde filling covered as a separate procedure only if performed more than one (1) year after the root canal therapy is completed.)

4. **Periodontic Services Includes the treatment plan, local anesthetics and post-surgical care).**
    a. Gingivectomy or gingivoplasty, per quadrant.
    b. Gingivectomy, per tooth (fewer than six (6) teeth).
    c. Gingival curettage.
    d. Pedicle or free soft tissue grafts, including donor sites.
    e. Osseous surgery, including flap entry and closure per quadrant.
    f. Osseous grafts, including flap entry, closure and donor sites.
    g. Muco-gingival surgery.

        (Only one (1) of the listed periodontic surgical procedures (a-g) is covered for each quadrant in a Calendar Year.)

    h. Occlusal adjustment not involving restorations and done in conjunction with periodontic surgery, per quadrant (limited to a maximum of four (4) quadrants in a Calendar Year.)
    i. Scaling and root planing (full mouth) limited to once each quadrant two(2) times per Calendar Year.
    j. Periodontal appliance limited to one(1) appliance every thirty-six(36) consecutive month period.

k. Periodontal prophylaxis.

5. **Oral Surgery** (Includes routine x-rays, the treatment plan and post surgical care.)
    a. Extractions
        i. Uncomplication extraction, one (1) or more teeth.
        ii. Surgical removal of erupted teeth, involving tissue flap and bone removal.
        iii. 3.Surgical removal of impacted teeth.
    b. Other Surgical Procedures
        i. Alveoplastry, per quadrant.
        ii. Stomtoplasty with ridge extension, per arch.
        iii. Excision of pericoronal gingival, per tooth.
        iv. Removal of palatal torus.
        v. Removal of mandibular tori, per quadrant.
        vi. Excision of hyperplastic tissue, per arch.
        vii. Removal of cyst or tumor.
        viii. Incision and drainage of abscess.
        ix. Closure of oral fistula of maxillary sinus.
        x. Reimplantation of tooth.
        xi. Frenectomy.
        xii. Suture of soft tissue injury.
        xiii. Sialolithotomy for removal of salivary calculus.
        xiv. Closure of salivary fistula.
        xv. Dilation of salivary duct.
        xvi. Sequestrectomy for osteomyelitis or bone abscess, superficial.
        xvii. Maxillary sinustomy for removal of tooth fragment or foreign body.
    c. General anesthesia is covered as separate procedure only when required for complex oral surgical procedures covered under this Plan (and only when not performed in a hospital).
    d. Prescriptions for Dental services.
6. Other Services
    a. Repair to bridges and full or partial dentures.
    b. Adding tooth to partial denture.
    c. Relining full or partial denture (upper or lower). Covered only if relining is done more than one (1) year after the initial installation and then not more than once each two (2) year period.
    d. Recementing of inlay, crown, bridge or space maintainer.
    e. Antibiotic drug injection.

TYPE III DENTAL EXPENSES

1. **Restorative Services -** Cast restorations and crowns are covered only when needed because of decay or injury and only when the tooth cannot be restored with a routine filling material. (See Type II Dental Expenses.)
    a. Gold Foil
    b. Gold inlays and onlays only if the tooth cannot be restored by a silver filing and (for replacements) at least five (5) years have elapsed since the last replacement.
    c. Porcelain inlay

d. 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. (The list of types of crowns still applies.
    i. Plastic (Acrylic)
    ii. Plastic, prefabricated
    iii. Plastic with non-precious or semi-precious metal
    iv. Porcelain
    v. Porcelain with non-precious or semi-precious metal or gold
    vi. Gold 3/4 for full cast
    vii. Non-precious or semi-precious metal full cast.
e. Steel post and composite or amalgam core, in addition to crown, is covered only for teeth that have had root canal therapy

2. **Prosthodontic Services** - Specialized techniques and characterizations are **not** covered.
    a. 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:
        i. If services are within the first twenty-four(24) months of coverage: Benefits are payable at fifty(50) percent of the benefit payable for Type III Dental Expenses.
        ii. If services are after the first twenty-four(24) months of coverage: Benefits are payable at the level indicated for Type III Dental Expenses.
    b. 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
    c. Replacement of the prosthodontic device is covered only if the original device cannot be made serviceable and both of the following time periods have been met:
        i. the Covered Person has been covered under this Plan for at least twelve(12) consecutive months, a
        ii. five(5) years have elapsed since the last placement.
            a. Fixed bridges - initial placement or replacement (each abutment and each pontic makes up a unit in a bridge).
                i. Bridge Abutments
                ii. Bridge pontics.
                    a. Cast metal, sanitary.
                    b. Plastic or porcelain with metal.
                    c. Slotted facing.
                    d. Slotted pontic.
                iii. Simple stress breakers, per unit.
                iv. Removable bridges, unilateral partial, one-piece chrome casting, clasp attachment, including pontics.
            b. full or Partial Dentures (any adjustments or repair to a denture within the first six (6) months after installation is not a Dental Expenses).
                i. Full dentures, upper or lower.
                ii. Partial dentures - (Includes base, all clasps, rests and teeth.)

a. Upper with two (2) Chrome clasps with rests, acrylic base.
b. Upper with chrome palatal bar and clasps, acrylic base.

iii. Lower, with two (2) chrome clasps with rests, acrylic base.
iv. Lower, with chrome lingual bar and clasps, acrylic base.
v. Stayplate base, upper or lower (anterior teeth only).

TYPE IV DENTAL EXPENSES

Services required for the treatment of Temporomandibular Joint Dysfunction are payable at 50% of the **Usual and Reasonable Charge**.

Only the Dental Services listed below will be considered a Covered Expense for the treatment of Temporomandibular Joint Dysfunction:

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.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an employee who is on a regular appointment with the University and who is scheduled to perform duties of his or her job with the University on a full-time basis.

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 as work on the last preceding regular work day.

Ambulatory Surgical Center means an institution or facility, either free standing or as part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing outpatient surgical procedures, has a staff of physicians, has continuous physician and nursing care by registered nurses (R.N.s), and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered an ambulatory surgical center.

Amendment means a formal document that changes the provisions of the Plan, 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 31 of the same year.

Children means natural children, step-children, adopted children or children placed with a covered Participant in anticipation of adoption and if the Participant is legal guardian.

Claims Review Committee means the three-member University committee appointed by the Vice President for Administrative Services with authority to review and consider Participant's 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, parent, brother, sister, child, or spouse's parent of the Covered Person.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuant means a Covered Person whose coverage is the result of having elected continuation coverage under the University's dental plan based upon a "qualifying event" as defined in this plan.

College See definition of University.

Cosmetic Procedure means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of 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 Active Employee, COBRA Continuant, or the eligible Dependent of an Active Employee or COBRA Continuant, 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 (listed on page 13).

Dentist means only a legally qualified dentist or physician authorized by his/her license to perform, at the time and place involved, the particular dental procedure rendered by him/her.

Dependent means:

1. The Active Employee's legal spouse. Such spouse must have met all requirements for a valid marriage contract in the state of marriage of such parties.

   The Participant's child or children who meets all of the following conditions:

   a. is unmarried;
   b. is a natural child, step-child, or legally adopted child of the Participant;
   c. is in the custody of and financially dependent upon the Participant. This requirement is waived if the Participant is required to provide coverage due to court order or divorce decree for a child not in his/her custody or not wholly dependent upon him/her;
   d. is less than nineteen (19) years of age. This requirement is waived if the child is at least nineteen (19) years of age but less than twenty-five (25) years of age, and is dependent upon the Participant for support, and is a regular full-time student at a college or university.

The age requirement above may also be waived for a Dependent child who is totally disabled, incapable of self-sustaining employment by reason of mental retardation or physical handicap, financially dependent upon the covered Participant for support, unmarried and covered under the Plan when reaching the limiting age of 19 years, or the otherwise limiting age of 25 years if a full-time student at an accredited college or university and financially dependent upon the covered participant at the time of the total disability. The Plan Administrator may require, at

reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.

Situations specifically excluded from the definition of a dependent are:

1. A spouse who is legally separated or divorced from the Participant; or
2. Any person on active military duty; or
3. Any person eligible for coverage under this Plan as an individual Participant; or
4. Any person who is covered as a dependent by more than one Participant of the University.

Dependent Coverage means eligibility under the terms of the Plan for benefits payable as a consequence of eligible expenses incurred for an illness or injury of a dependent.

Developmental Disability means a child's substantial handicap which:

1. results from mental retardation, cerebral palsy, epilepsy or other neurological disorder; and
2. is diagnosed by a physician as a permanent or long-term, continuing condition.

Diagnostic X-Ray and Laboratory Charges means covered charges for X-ray and laboratory examinations performed.

Disability and Disabled means the Covered Person's inability because of sickness or injury to work his 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; and
2. Is not a Disability Due to Injury.

   Elective Surgical Procedure means a surgical procedure which is not considered an emergency and which may be avoided without undue risk to the individual.

Eligible Class includes the following:

1. All full-time Active Employees of the University on regular appointment.
2. All full-time Active Employees of the University on regular appointment whose spouses are also full-time Active Employees of the University on regular appointment.

Eligible Expenses See Covered Expenses.

Employer is Missouri State University.

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

Family Unit is the covered Active Employee and the family members who are covered as Dependents under the Plan.

Full-time Student means a Participant's dependent child who is enrolled in and regularly attending an accredited college or university for the minimum number of credit hours required by that college or university in order to maintain full-time student status.

Generic Drug means a prescription drug that is not registered by a trademark.

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; 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.

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
2. A facility operating primarily for the treatment of substance abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a physician in regular attendance; continuously provides 24-hour a day nursing by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse. The facility must be certified by the Department of Mental Health for treatment of substance abuse.

Hospital Miscellaneous Expenses means the actual charges made by a hospital in its own behalf for services and supplies rendered to the Covered Person which are medically necessary for the treatment of such Covered Person. Hospital miscellaneous expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the hospital or otherwise.

Illness means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous condition of a Covered Person. A recurrent illness will be considered one illness unless

the con-current illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

Incurred Expenses means those services and supplies rendered to a Covered Person. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided.

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

Late Enrollee means a Covered Person who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan.

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.

Medicaid means the program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended from time to time.

Medical Care Facility means a Hospital, a facility that treats one of more specific ailments or any type of skilled nursing facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care, i.e., a life and/or limb threatening emergency medical condition, incurred by a Covered Person, and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended and approved by a physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare means the program established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled Health Insurance for the Aged Act and Title XVIII of the Social Security Act (amended by Public Law 89-97, 79) as amended from time to time.

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

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.

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, and Ambulatory Surgical Center, or the patient's home.

Participant means an Active Employee.

Participant Coverage means coverage hereunder providing the benefits payable.

Plan means Missouri State University Employee Benefit 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 the first day of the calendar year.

Prescription Drug means any of the following: a Food 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.

Qualified Beneficiary means any person who is covered under this Plan the day before a COBRA qualifying event occurs, e.g., an Active Employee, the Spouse of an Active Employee, or the eligible Dependents of an Active Employee.

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 rendering surgery and the second doctor are in conflict), including the doctor's exam of the patient and diagnostic testing.

Sickness, for all persons but a covered Dependent daughter, means illness, disease, or pregnancy. For a covered Dependent daughter, sickness means illness or disease, not including pregnancy or its complications.

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.

Totally Disability (Totally Disabled) means a physical state of a Covered Person resulting from an illness or injury which wholly prevents:

1. In the case of a Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and
2. In the case of a Dependent, from performing the normal activities of a person of like age and sex in good health.

University means an institution accredited in the current publication of accredited institutions of higher education. The term "University" in this document also refers to Missouri State University, the Fiduciary and Plan Administrator for benefits covered by this Plan.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider 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. The Plan will reimburse the actual billed charge if it is less than the Usual and Reasonable Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period is the time between the first day of employment and the first day of coverage under the Plan.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to Dental Expenses incurred by all Covered Persons (Participant or Dependent):

1. **Bite registrations.** Bite registrations or splinting.
2. **Bridge, crown or denture.** Any replacement of a bridge, crown or denture or Mandibular Orthopedic Repositioning Appliance which is or can be made useable according to common dental standards.
3. **Cosmetic reasons.** Expenses for services performed solely for cosmetic reasons.
4. **Crowns.** Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars.
5. **Dental services.** Dental services that do not meet common dental standards.
6. **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.
7. **Government coverage.** Expenses for charges made by a Hospital owned or operated by the United States Government and charges directly related to a military service connected sickness or injury. Such expenses will be covered if there is a legal obligation to pay such charges whether or not there is insurance.
8. **Hospital charges.** Services and supplies received from a Hospital.
9. **Instructional charges.** Instruction for plaque control, oral hygiene and diet.
10. **Medical services. Services that are deemed to be medical services.**

11. **No obligation to pay.** Expenses for charges that the Covered Person is not legally required to pay.
12. **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.
13. **Orthodontia.** Expenses for orthodontic services or supplies and orthodontics to correct malocclusion which may have caused Temporomandibular Joint Dysfunction symptoms.
14. **Procedures, appliances, or restorations. Procedures, appliances or restorations (except full dentures) whose main purpose is to:**
    a. Change vertical dimension; or
    b. Diagnosis or treat conditions or dysfunctions of the temporomandibular joint except as shown in the Dental Schedule of Benefits; or
    c. Restore occlusion and treat bruxism.
15. **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.
16. **Replacement charges.** Expenses for replacement of lost or stolen appliances. Expenses for replacement of a bridge, crown or denture or Mandibular Orthopedic Repositioning Appliance within five (5) years after the date it was originally installed unless:
    a. Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or
    b. The bridge, crown or denture, while in the mouth has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
17. **Surgical implants.** Expenses for surgical implant of any type including any prosthetic device attached to it.
18. **Unlawful charges.** To the extent that payment is unlawful where the Covered Person resides when the expenses are incurred.
19. **Unnecessary care.** Expenses for unnecessary care, treatment or surgery.
20. **Usual and Reasonable.** Charges that are in excess of the usual and reasonable charges for the service provided.
21. **Workers' Compensation.** Expenses for or in connection with an injury or a sickness which is covered under any Workers' Compensation or similar law.

HOW TO SUBMIT A CLAIM

When a Covered person has a claim to submit for payment, that person must:

1. Obtain a dental claim form from the University's Office of Human Resources or from the Claims Supervisor.
2. Complete the employee portion (Part I) of the dental claim form. ALL QUESTIONS MUST BE ANSWERED.
3. After the dental work is completed, have the dentist complete Part II of the dental claim form and submit it for payment.
4. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
    a. Name of Plan
    b. Employee's name
    c. Name of patient

d. Name, address, telephone number of the provider of services
e. Diagnosis
f. Type of service rendered, with diagnosis and/or procedure code
g. Date of services
h. Charges

5. Send the above information to the Claims Supervisor at this address:

Humana/Med-Pay, Inc.
P.O. Box 10909
Springfield, MO 65808
Telephone 417-886-6886 or 800-777-9087

Benefit payments will be paid to employees unless they have indicated on the claim form that the dentist is to be paid directly by Claims Supervisor. The Participant may be asked to make arrangements with the dentist to pay any non-covered expenses, the deductible, and/or the co-payment amounts.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Supervisor within 365 days of the date charges for the services were incurred, or within 90 days from the date a Covered Person terminates coverage. Claims filed later than that date will be declined or reduced unless it is not reasonably possible to submit the claim in that time (i.e., if the person has Coordination of Benefits, if the person is not legally capable of submitting the claim, etc.) If the Plan should terminate, however, 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.

PROCESSING OF THE FILED CLAIM

The Claims Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Covered Person seek a second opinion. Every effort will be made to process claims as quickly as possible. Although more complicated claims may take longer, most claims are processed within fourteen (14) days or less from the date they are received by the Claims Supervisor. The Participant will receive an Explanation of Benefits form which will indicate what services were paid for, how much was paid, who was paid, when payment was made, and why payment for some services was not made or was made only in part.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Supervisor will furnish the Participant with a written notice of this denial. This written notice may also indicate what other information, if any, would be necessary for the claim to be reconsidered.

PAYMENT OF CLAIMS

All Plan benefits are payable to the Participant, or subject to any written direction of the Participant. All or a portion of any indemnities provided by the Plan on account of dental or surgical services may, at the Participant's option unless the Participant requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the person rendering such services; however, if any such benefit remains unpaid at the death of the Participant or if the Participant is a minor or is, in the opinion of the University, legally incapable of giving a valid receipt and discharge for any payment, the University may, at its option, pay such benefits to any one or more of the following relatives of the Participant: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the University's obligation to the extent of such payment and the University will not be required to see the application of the money so paid.

OVERPAYMENT

If the Claims Supervisor makes an overpayment of benefits, the overpayment may be recovered. And if payments which should have been made under the University's Plan are made under other plans, the Supervisor may pay over to any other plan the correct amount. In this case, that amount will be counted as a benefit under the University's Plan.

CLAIM APPEAL PROCEDURE

If a claim is wholly or partially denied, the Claims Supervisor will inform the Participant in writing of the reason(s) for denial, either in an Explanation of Benefits (EOB) form or a letter. Such notice of denial will contain:

1. the specific reason or reasons for denial of the claim(s); and
2. a specific reference to the pertinent Plan provision(s) upon which the denial was based; and
3. a description of any additional materials or information required of the Participant in order to reconsider the claim(s); and
4. an explanation of the claims appeal review procedure.

The Participant may ask the Claims Supervisor in writing for a review of the denied claim within sixty (60) days of receipt of the denial notice. This written request for review should state the reasons why the Participant feels the claim should not have been denied. It should include any additional documents (dental records, etc.) which the Participant feels supports his/her claim. The Participant may also ask additional questions or make comments and may review pertinent documents. In normal cases, the Participant will receive the final decision within sixty (60) days of the date the request for review is received by the Claims Supervisor. In special cases requiring a delay, the Participant will receive notice of a final decision no later than one hundred and twenty (120) days after request for review is received by the Claims Supervisor.

If, after considering the request for review, the Claims Supervisor's final determination is to deny the claim, the Participant may continue the appeal procedure by requesting a review of the denied claim by the University's Claims Review Committee. Such request must be in writing and

submitted within sixty (60) days of receipt of the Claims Supervisor's final determination. The written request to the Claims Review Committee should be sent to:

The Office of Human Resources
ATTN: Claims Review Committee
901 South National Avenue
Springfield, Missouri 65897

and 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.

The Participant may submit to the Claims Review Committee such additional documents which he/she believes support the claim. The Participant may review pertinent documents and submit issues and comments in writing. The Claims Review Committee may, at its discretion, invite the Participant to present his or 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, benefit consultants, legal counsel or other persons whose information or expertise the Committee deems necessary or desirable. Where the Committee obtains additional facts or information 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 sixty (60) calendar days of arriving at its decision, but no later than sixty (60) calendar days from the close of the hearing. Such notification will include the specific reason(s) for the decision and reference the pertinent provision(s) of the Plan upon which the decision was based.

EXAMINATION

The University shall have the right and opportunity to have the Covered Person, whose injury or dental care is the basis of a claim hereunder, examined when and so often as it may be reasonably required during pendency of claim hereunder.

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 are paying. This provision is intended to prevent the payment of benefits which exceed expenses. When a Participant is covered by this Plan and another plan, or the Participant's Spouse is covered by this Plan and 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 rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due, up to 100% of the total allowable expenses. Only the amount paid by this Plan will be charged against this Plan's maximums.

The Coordination of Benefits provisions applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

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; or
2. Blue Cross and Blue Shield group plans; or
3. Group practice and other group prepayment plans; or
4. Federal government plans or programs; or
5. Other plans required or provided by law; or
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable, it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of **HMO** (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, the Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductions. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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 without a coordination provision will pay their benefits by these rules up the Allowable Charge.
3. Plans with a coordination provision will pay their benefits by following these rules, 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 Active Employee who is neither laid off or 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 Active 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 Active Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as 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.
    d. The benefits of a benefit plan which covers a person as an Active Employee who is neither laid off nor retired or a Dependent of an Active Employee who is neither laid off or retired are determined before those benefits of a plan which covers that person as a COBRA beneficiary.
    e. 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.
    f. When a child's parents are divorced or legally separated, these rules 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 consider 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 a 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 seek 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.

g. 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.

4. If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

COBRA CONTINUATION OPTIONS

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus the administration fee allowed by law) must be paid by the continuing person. Coverage will end if the individual fails to make timely payment of contributions or premiums (within a maximum of 45 days during the initial premium/contribution and 30 days thereafter). This law is referred to as **"COBRA"**, which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Complete instructions on **COBRA** will be provided by the Plan Administrator to Covered Persons who become qualified beneficiaries under **COBRA**.

BENEFITS AFFECTED BY COBRA

There are two categories of benefits that may be continued under COBRA.

1. "Core benefits" are Medical Benefits. Any **COBRA** continuance option must include the offering of core benefits for which the person was covered just prior to the **COBRA** "qualifying event" (an event which qualifies a person for continued coverage under **COBRA**). A child born to or placed for adoption with the covered employee during the period of **COBRA** coverage must also be offered these core benefits.
2. "Non-core benefits" include Dental Benefits, Vision care Benefits and Flexible Spending Accounts under Section 125 (Cafeteria-type) plans.

If the "qualified beneficiary" (a person eligible for **COBRA** continuance) was covered by these core and non-core benefits prior to termination, the individual may, but is not required to,

continue them under **COBRA**. Which benefits, if any, are to be continued will be indicated by the qualified beneficiary at the time of **COBRA** enrollment.

Life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefit (if a part of the Employer's plan) are not considered for continuance under **COBRA.**

Maximum Time Periods. Continuation will be available for a qualified beneficiary up to the maximum time period shown in item (1), (2) or (3) below. Combined qualifying events will not continue a beneficiary's coverage for more than 36 months beyond the date of the original qualifying event.

1. Up to 18 months for an Active Employee and his covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct.

   Note: An individual who is disabled may have COBRA coverage extended (and an extra fee charged) for 18 months to 29 months provided that:

   a. the individual is determined as being disabled for Social Security purposes on the date of the qualifying event or within the first 60 days of COBRA coverage; and
   b. the individual notifies the Plan Administrator within 60 days of the Social Security Administration's determination of disability and within the original 18-month COBRA period which applies to the person.
2. Up to 36 months for:
   a. a covered child who ceases to be an eligible Dependent;
   b. a covered Dependent of a deceased Active Employee;
   c. a former covered Spouse whose coverage ceases due to divorce or legal separation; or
   d. a covered Dependent when the Active Employee's coverage ceases due to entitlement to Medicare.
3. There is a special continuation period for Retired Employees and their Dependents when the Employer declares bankruptcy under Title 11 of the United States Code and the Retired Employees and their Dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Coverage will be continued for each person until the date of that person's death. However, the surviving Spouse or children of a deceased Retired Employee, may continue coverage for up to a maximum of 36 months following the Retired Employee's death. For this item 3, coverage does not terminate when the person becomes eligible for Medicare.

Continued coverage may also cease before the end of the maximum period on the earliest of:

1. The date that the Employer ceases to provide a group health plan to any Employee; or
2. The date that the qualified beneficiary first becomes, after the date of election, (a) covered under any other group health plan (as an employee or otherwise), or (b) entitled to benefits under Medicare (except as stated in item 3 above). However, a qualified

beneficiary who becomes covered under a group health plan which has a Pre-Existing conditions limit must be allowed to continue COBRA coverage for the length of a Pre-Existing condition limit or to the COBRA maximum time period, if less. COBRA coverage may be terminated of the qualified beneficiary becomes covered under a group health plan with a Pre-Existing conditions limit, if the Pre-Existing conditions limit does not apply to (or is satisfied by) the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA, or the Public Health Services Act.

Notice Requirements. When coverage terminates due to an Active Employee's death, termination or eligibility for Medicare, the Employer has 30 days in which to notify the Plan Administrator of the qualifying event.

When coverage terminates due to divorce, legal separation or change of Dependent status, the qualified beneficiary has 60 days from the qualifying event or from the date coverage terminates in which to notify the Plan Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within 14 days of receiving notice of the qualifying event. Covered Persons then have 60 days in which to elect continuation. The 60 day period is measured from the later of the date coverage terminates or the date notice of the right to continue is sent. If continuation is not elected in that 60 day period, then the right to elect continuation ceases.

RESPONSIBILITIES FOR PLAN ADMINISTRATOR

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is Missouri State University which shall have the authority to control and manage the operation and administration of the Plan. The Named Administrator may delegate responsibilities for the operation and administration of the Plan. The University shall have the authority to amend the Plan, to determine its policies, to appoint and remove supervisors, adjust their compensation (if any), and exercise general administrative authority. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefit hereunder.

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.

HIPAA Privacy Rule Compliance

The Employee Benefit Plan ("Plan") is amended as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to allow the disclosure of Protected Health Information ("PHI"), as defined under

HIPAA, to Missouri State University ("Plan Sponsor") for the purposes specified below. If the terms or conditions of the plan documents conflict with this Amendment, this Amendment shall control.

1. Disclosure of Protected Health Information ("PHI") to Missouri State University. The Plan shall disclose PHI to the Plan Sponsor only to extent necessary for the Plan Sponsor to perform the following Plan Administrative functions:
    a. Quality assurance/auditing
    b. Precertification, utilization review, and large case management
    c. Utilization review
    d. Determination of written appeals made by Participants
    e. Participant requested assistance with claims and claims processing
    f. Monitoring
    g. Due diligence and financial analysis including:
        i. Budgeting
        ii. Accounting
        iii. Premium payments
        iv. Trending and utilization analysis
    h. Plan member enrollment/disenrollment
    i. Bids
    j. Underwriting
    k. Stop-loss claims
    l. Coordination of benefits
    m. Plan or benefit design
    n. Technology support and information services
    o. Legal review and defense
    p. Claims activity reports
2. Use and Disclosure of PHI by Plan Sponsor. The Plan Sponsor shall use and/or disclose PHI only to the extent necessary to perform the following Plan Administration functions, which it performs on behalf of the Plan:
    a. Quality assurance/auditing
    b. Precertification, utilization review, and large case management
    c. Utilization review
    d. Determination of written appeals made by Participants
    e. Participant requested assistance with claims and claims processing
    f. Monitoring
    g. Due diligence and financial analysis including
        i. Budgeting
        ii. Accounting
        iii. Premium payments
        iv. Trending and utilization analysis
    h. Plan member enrollment/disenrollment
    i. Bids
    j. Underwriting
    k. Stop-loss claims
    l. Coordination of benefits

m. Plan or benefit design
n. Technology support and information services
o. Legal review and defense

3. Plan Sponsor Certification. The Plan agrees that it will only disclose PHI to the Plan Sponsor upon receipt of a certification that this Amendment has been adopted and the Plan Sponsor agrees to abide by such conditions. The Plan Sponsor is subject to the following:
    a. Prohibition on Unauthorized Use or Disclosure of PHI. The Plan Sponsor will not use or disclose any PHI received from the Plan, except as permitted in these documents or required by law.
    b. Subcontractors and Agents. The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide PHI to agree to written contractual provision that impose at least the same obligations to protect PHI as are imposed on the Plan Sponsor.
    c. Permitted Purposes. The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other of Plan Sponsor's benefits or employee benefit plans.
    d. Reporting. The Plan Sponsor will report to the Plan any impermissible or improper use or disclosure of PHI not authorized by the plan documents.
    e. Access to PHI by Participants. The Plan Sponsor will make PHI available to the Plan to permit Participants to inspect and copy their PHI contained in the designated record set.
    f. Correction of PHI. The Plan Sponsor will make a Participant's PHI available to the Plan to permit Participants to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and the Plan Sponsor will incorporate amendments provided by the Plan.
    g. Accounting of PHI. The Plan Sponsor will make a Participants' PHI available to permit the Plan to provide an accounting of disclosure.
    h. Disclosure to Government Agencies. The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of PHI available to the Plan and to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.
    i. Return or Destruction of Health Information. When the PHI is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all PHI that the Plan Sponsor received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
    j. Minimum Necessary Request. The Plan Sponsor will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions, for which the information is requested.
4. Adequate Separation. the Plan Sponsor represents that adequate separation exists between the Plan and the Plan Sponsor so that PHI will be used only for plan administration. The following employees or persons under the control of the Plan

Sponsor have access to Participants' PHI for the purposes set forth under Number 1 above.

a. Employees within the Office of Human Resources who have benefit plan responsibilities
b. Members of the University's Claims Review Committee,
c. The University's General Counsel,
d. Employees within the Office of the Internal Auditor who have auditing responsibilities for the benefit plans,
e. Employees within the Computer Services Department who support the technology transmitting or storing of PHI.

5. Adequate Separation Certification. The Plan requires the Plan Sponsor to certify that the employees identified above are the only employees who will access and use Participants' PHI. The Plan Sponsor must further certify that such employees will only access and use PHI for the purposes set forth under number 1 above.
6. Reports of Non-Compliance. Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Health Plan's Privacy Official at 417-836-6616.

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 from contributions made by the covered Active Employee.

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

Benefits are paid directly from the Plan through the Claims Supervisor.

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/her spouse, parent, adult child, guardian of a minor child, brother, sister, or other relative of a dependent of such Participant or former Participant, as the University may determine, and any such application shall be complete discharge of all liability with respect to such benefit payment.

PLAN AMENDMENTS

This document contains all the terms of the Plan and may be amended from time to time by the University. Any changes made shall be binding on each Participant and on any other Covered Person referred to in this Plan. Changes to the Plan will be provided to all Covered Persons within sixty (60) days of the effective date of the change.

PLAN IS NOT A CONTRACT

This document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Active Employee of the University the right to be retained in the service of the University or to interfere with the right of the University to discharge or otherwise terminate the employment of any Active Employee.

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 requirements 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 LIMITATIONS

If any time limitation of the Plan with respect to giving notice 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.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

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.

FREE CHOICE OF PHYSICIAN

The Covered Person shall have free choice of any legally qualified physician or surgeon and the physician-patient relationship shall be maintained.

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 reference convenience 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.

TERMINATION OF PLAN

The University reserves the right at any time to terminate the Plan by written notice to the Claims Supervisor. Valid claims arising before such termination will be paid according to the procedure established.

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 Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded 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 Participants and COBRA Continuants, if any, as required by the Plan.

PLAN NAME

Missouri State University Employee Benefit Plan

PLAN EFFECTIVE DATE

September 1, 1988

PLAN YEAR

January 1 through December 31

EMPLOYER INFORMATION

Missouri State University
901 South National Avenue
Springfield, Missouri 65897
417-836-6616

PLAN ADMINISTRATOR

Missouri State University
901 South National Avenue
Springfield, Missouri 65897
417-836-6616

CLAIMS SUPERVISOR

Med-Pay, Inc.
1650 East Battlefield
P.O. Box 10909
Springfield, Missouri 65808
417-886-6886 or 800-777-9087